Policy Feedback Comments and Clarifications

Policies issued January 3, 2011

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Policy Feedback Comments and Clarification

In order to provide a clear understanding of the thought behind the development of the Division of Disability and Rehabilitative Services (DDRS) policies, we are committed to providing a response to every comment and question received relating to policies submitted for public review.

Below are the responses to the questions and comments we received for the draft policies released on January 3, 2011.

BQIS Complaints: Supported Living Services & Supports

1. **The policy appears appropriate overall, but appears to have omissions and over-extended time frames for resolution of complaints. In the initial reporting section, the policy does not identify the requirements for notifying the individual's legal representative of critical and non-critical events/reports. This should exist and be defined. An express definition and examples of "indirect threats" that qualify as critical occurrences for which complaints should be filed would be useful.**

   Agree that an individual's legal rep should be notified of critical events, notifying them of non-critical complaints may be good practice we are not going to prescribe it here. This change has been made to the policy.

2. **In the "Protected Health Information" section, the correct acronym is "HIPAA" not "HIPPA".**

   Agree. This oversight has been corrected in the policy.

3. **The time frames for investigative summaries to 30 and 60 days as it appears in (b) and (c) were formerly 10 and 15 days, respectively. We believe the amount of time to complete these summaries should be kept at or much closer to the former time requirements of 10 and 15 days, than to the proposed time frames. The time of initial submission of the corrective action plan (CAP), whether with the investigative summary or at another time, should be expressly defined. Also, providers should receive only a very short time frame for a second chance to submit an appropriate CAP when the provider has not submitted an appropriate and/or timely initial CAP.**

   We struggle to meet the 10-15 day requirements with current staff. We wanted to give more realistic timeframes.

4. **Policy mentions reporting to the BQIS Field Director of Quality Operations – just needs some clarification**
   - **How will people know to call this person?**
   - **Will there be a separate communication with this number?**
   - **When we look at the documentation required in the home policy there is no mention of having this number available, just the Waiver Ombudsman**

   Or did I read this incorrectly and the intent is that when a complaint is made, the report to the FDQA is internally directed to this person?

   Call this person as directed in the policy.
   The number is (812) 524-8529

5. **Documentation Review - Should Incident Reports be added?**

   Yes. Change has been made to the policy.

6. **Validation of Caps – I'd suggest reversing points 1 and 2 - it's a semantics issue, but generally better to start with the positive resolution.**

   Agree. Change has been made to the policy.

7. **Sanctions Committee - Will there be a separate document which outlines the Sanctions Committee – how often they meet, what is the extent of their authorization for sanctioning actions, etc.?**

   Yes. This policy will be available for review shortly.

8. **In policy statement, add the word 'of' in the first sentence between 'policy' and 'the Bureau.'**

   Agree. This oversight has been addressed in the policy.

9. **Under the Documentation Review section, item 1d, remove the's' on services.**

   Agree. This oversight has been addressed in the policy.

10. **Reporting/Interviews: Define legal representatives.**

    Agree. This has been addressed in the definition section of the policy.

11. **Submission of Corrective Action Plan: states "as directed" define timeframe or is it the 30 days as with all CAPs**

    For complaints it is 5 days for the first CAP and 3 days if there is a follow up CAP (non-acceptance or non-compliance). This is the current standard for complaints.

12. **Additional Notification: Notification of suspected fraud: Define who is notifying and what other entity as determined by BQIS.**

    It is not relevant. Any DDRS employee can report fraud.

13. **Interviews: 2. BQIS interviews with other parties shall be 1:1 unless BQIS determines a need for a BQIS selected 3rd party. This is pretty vague and allowing BQIS to select the third party could have some effect on the outcome. Is there a reason that this section does not acknowledge a "legal representative" or "guardian" as in #1?**

Sometimes it is appropriate to talk to a DSP, or other employee, without a supervisor present.

14. **There is no provision in either of these articles for the person being interviewed to request assistance from a person of their choice/legal representative.**

    Agree. This change has been made to the policy.

15. **Who is the BQIS Field Director of Quality Assurance?**

    Genna Lynn.

16. **Classification of complaint - #1.a.i.—a time frame should be stated for when the legal representative must be contacted.**

    Time frame is addressed in "Initial Contact" #2.

17. **p. 1. Photographic Documentation: Has permission to take photos of the individual been secured from the individual or the legal representative? Maybe require a signature/release form?**

    There is a photo release form, if needed.

18. **Investigative summaries – I don't know if these timeframes are a revision of previous policy, as this is my first experience reviewing these policies. However, I do feel these timeframes should be decreased, for the welfare of the individual. I would suggest 3 days max for urgent matters, 15 days for critical and 30 days for non-critical.**

    These are a decrease from previously suggested timeframes. We feel this is adequate as written.

Behavior Support Plan

1. **The policy does not address setting up defined point of meetings, plan review and reconsideration upon the occurrence of particular, unanticipated events such as unexpected and not previously seen types of conduct by an individual. Some list of examples of defined events that should cause a meeting and review of the plan should be included for the periods between the annual reviews.**

   We are requiring "quarterly reports" to team members, including graphic presentation of progress. Any team member can request a team meeting at any time should concerns arise over any behavioral issue. There is always an annual team meeting with all providers.

2. **Under 2(e) of the section entitled "Creating Behavioral Supports," (CBS), it is not clear exactly what the reference to "operational definition" is to mean or include. A template for what should be included in the operational definition could be helpful.**

   "Operational definition" has been defined in the policy.

3. **As a final observation, we are concerned with the amount of time allowed for in the CBS to complete an assessment (28 days); develop a plan (14 days); and implement the plan (14 days). The total amount of days for this process is 56 days, or nearly two (2) months. Given that the purpose of this process is to stop negative behavior and the negative effect on the individual, as well as those around the individual, we would argue that much shorter time frames for the completion and implementation of these processes should be adopted.**

   This is why there are emergency behavioral supports

4. **Creating Behavioral Supports #1. c. – <u>add</u> "or within 14 days of receipt of Human Rights Approval".**

   A bullet has been added to require HRC approval when a restrictive intervention is used.

5. **Under the section "Staff Training Required", please provide additional information/ definition on the term "competency based training." What all would this include and who would verify the training was indeed "competency based"?**

   Agree. This has been addressed in the definitions section of the policy.

6. **Do the members of the team decided who is responsible for completing each assessment?**

   Yes. This is defined in the role of the IST (IST policy)

7. **What is a meaningful day assessment? How are you defining this? Are there approved assessments out there?**

   Meaningful day is defined in a BQIS fact sheet found at: http://www.in.gov/fssa/ddrs/3948.htm titled "Quality of Life: Meaningful Day". No assessment is being recommended as approved, however the action steps in the fact sheet present themselves as a straightforward measurement for meaningful day.

8. **There appears to be a conflict in the language regarding required staff training, in that this policy states the BSP will train the provider's supervisory staff who in turn will be responsible to train/provide competency based training for all direct support professionals. The conflicts we see: Policy on Training of Direct Support Professional Staff under initial training of DSP staff #3, also conflicts with the Policy on Personnel Polices & Manual j ii, and k i and ii., technically could be in conflict with the policy on Provider Code of Ethics 4 (a) and with the Policy of Restrictive Interventions, Including Restraints staff training #2 and #3**

   There is no conflict as we see it. The qualification of being trained by a behavior specialist as outlined in the BSP policy is sufficient for the requirement you observed to be a conflict.

9. **Creating Behavioral Supports Section – In working with behavioral services providers, they are not close to the time frames outlined for completing functional assessments and developing the BSP.**

While we would like to see these things happen in a timely manner, I don't know if these time frames are realistic. Who will monitor this and what is the outcome if the timeframes are not followed?

These timeframes were developed with other behavioral professionals and were deemed realistic. With that being said, we will expand the 28 day timeframe to 45 days. The case manager and BQIS will monitor. If the timeframes are not followed a BQIS Complaint, Incident Report, etc. could be the outcome.

10. **Staff Training Required: The policy states that the Providers supervisory staff will train the direct support professionals. While this should be an option I feel that it should be an additional option and the Behavior Support Therapist should be the primary on training DSP's to ensure the transfer of direct knowledge.**

    We agree that the BST would be the ideal trainer, but it has been indicated to us that this is not a reasonable expectation at this time. Behavior providers are encouraged to train direct service staff as is possible and this has been added to the policy as an option.

11. **Creating Behavior Supports #4 - Delete "that include graphs of both targeted behavior and replacement behavior". The content and kind/type of clinical report needs to be left to the discretion and judgment of the behavior provider as it is with every other professional provider - speech/hearing/vision/OT/PT/etc. We do not believe the state policy should dictate how data is displayed.**

    This visual representation makes it easier to identify trends in data for all IST team members, including family members and legal guardians.

12. **Definitions – "'Restrictive intervention' means an intervention that restricts the rights or freedom of movement of a person with a disability." This definition is so broad that even a brief (less than 5 seconds) physical hold or redirection or block would constitute a restrictive intervention. There are very appropriate and re-directive physical touches. We recommend differentiating between touch and restraint.**

    The definition has been amended slightly in the policy.

13. **Staff Training Required – this part of the policy effectively removes the BMAN-DSP link at the critical training stage. That interaction is crucial to an understanding of the intricacies of the behavior plan. It is important for direct support staff to be able to ask questions and communicate issues directly with the BMAN responsible for the plan. Having attended many BSP trainings, I can attest to the positive outcomes of this direct training. BMAN providers bill at $70/hr. Surely this contact with staff directly responsible for the outcome of the plans is time and money well spent.**

We agree, but as stated earlier, it has been indicated to us that this is not feasible at this time. A change in the policy clearly outlines this direct training as an option.

14. **I may be a little late with my response to the BSP Policy Draft. Overall the policy looks well written and in compliance with 460 IAC 6-18. This being said I do have some concerns about the section on staff training. I realize this is an ongoing problem, and RHS providers struggle with staff turnover and being able to quickly train staff on a BSP so they may work a site. However, 460 IAC 6-18-2 Sec. 2 (g)(1)(2) seems to indicate that training is the responsibility of the BSP provider. I do know that if direct care staff is not trained BQIS cites both the BSP provider and RHS provider and has in my experience required that training be done by the behavior services provider. Also, when a behavioral event happens requiring a BDDS Incident Report, the question is many times asked if the BSP addressed the problem and if staff have been trained by the behavior services provider. At least in a number of my cases this has been the question. Another issue is I have trained supervisory personnel in the past and when they have trained the staff, they give their own version. Staff may ask questions about why a procedure is included and the supervisory staff will not know the research behind the intervention. For instance, just recently I did a training in which a DRO-DRA program was included in the plan. The plan had been in place for some time, the direct care staff was not implementing the program correctly. During the training for everyone, I explained the reason the individual was to receive attention within a certain time frame if they did not engage in behavior. This was done by presenting the concept of establishing operations, baseline data and schedules of reinforcement. I also had an opportunity to demonstrate an extinction procedure during the training as the individual came into the room and engaged in a targeted behavior. Once they saw the procedure demonstrated they were able to comprehend why it was in the plan. The supervisory staff was present and had they been doing the training it is unlikely they would have implemented the procedure. In fact they said they would not. Without making this any longer I hope this communicates my concerns.**

    Training is still the responsibility of a BSP provider, just in a more indirect manner.

    We'll address your statement about the BDDS incident report.

15. **What should the role of the Human Rights Committee be in BSP's?**

    This has been addressed in the HRC policy.

16. **Surprised that the BSP is a component of the ISP; seems like it places it in a different category than goals, risk plans, etc, which are also really part of the plan.**

    We feel this is appropriate.

17. **We recommend that language be added with respect to the timeline between 1.b. and 1.c. in cases when significant difficulties are encountered in obtaining consent. In conjunction, we recommend that language be inserted describing a procedure for resolving unresponsiveness or undue resistance of a legal representative.**

Report unresponsiveness or consent obtainment to the case manager to address.

In an emergency situation please refer to the “Use of Restrictive Interventions in a Behavioral Emergency” section of the “Use of Restrictive Interventions” policy.

18. **Under section “Creating Behavioral Supports”: 1. a. inclusion of when the specific time clock of the 28 days begins---too vague- what drives the specific initiation date?**

    We feel the policy adequately addresses your concern. a. i. addressees when an individual has a provider the clock begins the day the behavior is documented in the ISP. Ii. Is saying for individuals without a behavior provider, the clock starts when the new provider is added to the IST.

19. **Add to “Definitions” a definition for (1) positive supports and (2) positive behavioral interventions.**

    A definition for “positive supports” has been added to the policy and “behavioral interventions” has been removed.

20. **This specifies that, "This belief requires a behavioral support plan that is the result of a careful and deliberative process conducted by qualified entities.", but does not specify who those 'qualified entities' are. The current 460 allows for anyone with a Master's degree in psychology, social work, counseling, or special education. These specialty areas do not necessarily provide a graduate with the skills necessary to understand or change behavior. Could there be some requirement towards education/training in behavior analysis? Currently other states, including Tennessee and Georgia, require that all behavior management services be provided or reviewed by a Board Certified Behavior Analyst. I understand that would be nearly impossible for all services to be provided by a Board Certified Behavior Analyst, currently in Indiana, given the small number of Board Certified Behavior Analysts in the state. However, we do need to provide a better, higher quality of behavioral service if we hope to see long-term success with our individuals currently living in and transitioning to the community. In my experience, many of the more challenging behaviors encountered in the community are above the skill-level of the current, average behavior clinician, but with additional, specified training and education requirements, this does not have to remain the case. I hope that we can move to, at least, a review or supervisory component at some point that would require oversight by more qualified and expert clinicians, certainly in situations of individuals presenting with greater behavioral challenges.**

    I understand that the requirement for a 'Level 1' may be removed. In many cases, the psychologist who performs the 'Level 1' duties does not necessarily know more about behavior than the clinician providing the behavior management services. However, we do have in Indiana, a number of psychologists who are quite knowledgeable in this area who can help bridge the gap for clinicians whose skills are weaker, when utilized properly. In addition, given the increased tendency towards dual diagnosis and mental health concerns within the individuals to whom we provide services, the inclusion of a psychologist in the consultation for and review of a functional assessment and behavior support plan can be essential in providing comprehensive and appropriate service. I hope that the requirement for 'Level 1' will remain, if not for all cases, at least for those in which the individual has a mental health diagnosis, or exhibits behaviors, which may indicate mental health symptoms.

We don't necessarily disagree, but it is not the right time to address these concerns.

21. **Implementation of the BSP requires the Behavior Consultant completes required staff training. How will you hold residential companies accountable to this policy to cooperate with this timeline? It is my personal experience that residential companies are not responsive to inquiries to hold the staff training. This requires extensive follow up with QMRP's and/or supervisory staff to schedule the training and many times takes up to a month provided the residential company does not call to cancel and reschedule. Behavior consultants must have at least a two month period to complete the FBA and BSP and be allowed to schedule and complete staff training during the third month for any realistic policy to have successful adherence.**

    Notify the case manager or call a Team Meeting if RHS provider is not cooperating.

Documentation of Criminal Histories

1. **This policy appears to be fairly comprehensive. Under section 3(a) consideration should be given to changing the reference of "A sex crime;" to "Any sex crime," or adding a separate crime identifier to catch "Any crime in which sexual conduct was involved."**

    We believe the policy covers this as written.

2. **The term "abuse" should be included and defined in b and c to disclose any crime involving the concept of abuse of another individual. There should also be requirements for periodic follow-up criminal history checks after the individual begins employment or involvement with the provider.**

    Agree. Change made to the policy.

3. **So I'm clear, this policy is just saying the documentation that these things have been checked is required, correct?**

    Yes.

4. **Delete 1d – duplicative of 2(a)**

    We disagree.

5. **2a –Object - Should be able to verify by any method**

    We agree. This has been addressed in the policy.

6. **Delete 3 a-l when we request criminal histories we receive all information – not specific to the crimes listed in the DDRS policy draft**

    That is fine, and you can make a decision as an employer beyond the crimes we are prescribing be documented. There is certainly no penalty for documenting beyond our requirements.

7. **Delete #5 and #6 as they are not legal actions.**

   Agree about #6. This change has been made to the policy. #5 will remain.

8. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   Disagree. These employees and persons should be held to same standard. We have removed "volunteers".

9. **We recommend that 1. d. "mirrors" the language at item 3 of the Employment of Persons with Convictions of Prohibited Offenses/Non-Residency Status policy, so that it reads "for any alien, verification of United States residency status."**

   Agree. Change has been made to the policy.

10. **Under item 3. e., we recommend including clarification similar to the current rule that states "if the person's conviction for theft occurred less than ten (10) years before the person's employment application date, except as provided in IC 16-27-2-5(a)(5).**
    a. **If this language is not included, will there be a "grandfathering" provision for those employees who met the current requirements, but would not meet the new policy?**

    Agree. This language has been added to the policy.

11. **Under item 3. k., the current rule does not include misdemeanor battery charges. Will there be a "grandfathering" provision for those employees who met the current requirements, but would not meet the new policy?**

    Misdemeanor battery has been eliminated from the policy.

12. **It is our understanding that language will be added to item 3. l. to read "any *felony* offense relating to alcohol or a controlled substance."**

    Yes.

13. **Under 1 c. What other professional registry searches are you referring to? Could you please provide more clarification?**

    Professional Licensing Agency is a good example. What this language is trying to get at is if an employee says they are a licensed occupational therapist, as an example, that you verify they have this licensure.

14. **#3. d. – What exactly do you mean by moral turpitude? L. Is there no time limit on this offense? Under this verbiage I couldn't even hire the Governor as a staff member. I could support in the past say three years? They would be fired if it were found to be a current problem.**

    "Moral turpitude" has been eliminated from the policy.

15. **#4 – Where do we search for this type of information on an individual?**

    Professional Licensing Agency, Nurse Aide Registry, any other relevant licensure database

16. **Please clarify if national criminal history checks would satisfy the requirement for 2.b.**

    No, it would not capture the local information.

17. **Please provide a definition of cause to investigate, (if there is an arrest, police investigation, conviction?) How will an agency know if there is an issue to investigate? Do we depend on the staff person to inform us if there is an issue? It will be difficult for agencies to know when cause to investigate should occur.**

    This is left up to the agency's discretion. Obviously if you hear someone was arrested or involved in an incident you may want to look into this.

18. **Are there conflicting policies on the legality of conducting criminal histories on existing staff except at the time of hire?**

    We do not feel what we have in this policy conflicts with the legality of conducting criminal histories.

19. **#6. Upon a Provider requesting approval for a new service, current or incumbent owners, directors, officers, employees, directors, contractors, subcontractors, volunteers or agents for whom the Provider has not obtained a criminal history consistent with this rule shall undergo a criminal history search as outlined in this policy as a requirement for approval of the new service.**
    a. **Does this mean all existing staff will need to have a new criminal history search at the time there is a new service approved? We need some clarification on when to conduct and if this includes existing staff.**

    This has been removed from the policy.

20. **Are agencies permitted to run new criminal history checks on existing staff periodically?**

    We have found no evidence that this is not allowed, but we are not requiring it.

21. **#2a. "Electronic verification of Social Security records confirming identity and address history; This needs to be clarified if it includes present employees, or only new hires. If it includes present employees it needs to give a timeline for when those checks will be completed.**

    We are removing this from the policy. Verification is not a requirement.

22. **2b. "Criminal history search from each state, county, district, parish and city…." – We have had difficulty getting county background checks from certain counties, and have gone to the city and have been unable to attain them from there as well. There needs to be a provision for if the county does not do the check. We have been told from these counties that we can complete a state background check, but that is all.**

If a county will not provide these records, there is a practice of signing off on a letter stating you asked the counties in question for the records and they would not provide them.

23. **Also, from reading through the policy, I understand that a new background check shall be done if there is just cause. However, I did not see a policy on a requirement to update the background check every 3 years. This needs to be clarified if this will still be a requirement.**

    Not a requirement.

24. **It would be helpful for providers if this policy also called for the State to implement a DSP registry where providers can report DSP's terminated for abuse/neglect/exploitation. Providers would then be required to check all new hire candidates against this registry. This would prevent providers from hiring those individuals who has slipped through the legal cracks and have no record.**

    This is a nice thought, but this is not the appropriate time.

25. **The documentation applies to volunteers as well. However, we do not have a mechanism to check a volunteer's status in regards to citizenship or legal residency like we do with those we employ. The I-9 verification process and associated checking with it are not done except in an employment situation. This policy will discourage the development and maintenance of volunteer programs.**

    Agree. Changes have been made to this policy.

26. **Does this policy apply to board members? If so, this policy seems over-reaching. These extra requirements will hamper the recruitment of community members to these positions, which is already a difficult task. Each agency carries Directors and Officers insurance as a legal protection and these volunteers do not have unsupervised access to consumers. However, a check of the Medicaid Fraud registry on all potential board members may be prudent.**

    If the board member does not work for the provider agency, no.

27. **The inclusion of electronic verification of Social Security records involves additional costs to the agency to run background checks. The social security administration's e-verify program does not provide this level of information and has been shown to be error prone in determining eligibility to work in the United States.**

    This will be removed from the policy.

28. **The requirement to obtain criminal histories (2(b)) from any location where someone lived or worked is excessive and may result in having someone obtain many multiples of criminal**

histories. Using myself as an example, I would have had to provide a criminal history from the State of Ohio, the Commonwealth of Kentucky, Hamilton County, Ohio, Warren County, Ohio, and Campbell County, Kentucky.

We believe this is a reasonable request, remembering that it is only relating to the locations within the last 3 years, and is not beyond current requirements.

29. **The current regulations include a theft provision but include a time limit of ten (10) years. Given the potential nature of many thefts (especially misdemeanor theft) this permanent exclusion will keep out many good people. Please consider the time limitation and give potential employees the chance to explain the circumstances to employers.**

    Time limitation has been added to the policy.

30. **Any offense relating to alcohol or a controlled substance will exclude many potential employees with convictions for underage drinking (illegal consumption) or public intoxication. Instead of such a broad provision, consider asking to see a negative drug screening if such a conviction is on the record within a certain time period.**

    This has been addressed in the policy.

31. **The professional registry searches called for in (4) are not specified. What specifically is required? Right now, we check the CNA database as required by the state. We also check others that are not required.**

    No specific additional registry at this time.

32. **2a) after speaking with the public affairs liaison at Anderson office of SSA, not sure this is even possible. Was told employers can use e-verfy to verify a valid SSN but this database could not be used to verify identity and absolutely not address history.**

    Agree. This has been addressed in the policy.

33. **When this policy is finalized, would the Provider need to go back and complete checks (professional registry, electronic verification of Social Security records, etc.) for all current employees that began prior to this policy being put in to effect? Or, would the Provider need to complete these checks for former employees only if we are requesting approval for a new service?**

    Only for new hires.

Employment of Persons with Convictions or non-residency status

1. **We would contend that 1(a) should reference "Any sex crime," and that b and c should include any crime that includes conduct and results that meet a definition for abuse. While the following action does not necessarily always involve criminal charges, any past involvement by a subject individual as a party in any "Child In Need of Services" (CHINS) proceeding which resulted in the juvenile court finding the ward to be in need of services should be subject to disclosure and documentation. A standard for potential disqualification from a position of employment involving the care of vulnerable individuals based on prior negative CHINS findings, especially children, should be established.**

   We may address this in the future, but not at this time.

2. **Question about Section 1 item I "Any offense relating to alcohol or a controlled substance" - Does this mean, a person charged with above is prohibited from employment? Or does it mean convicted.**

   - **I think the above should be two separate items. An offense relating to Alcohol might be defined as a pattern of alcohol abuse consisting of two or more charges. All other alcohol related charges would fall under misdemeanors or criminal conversion.**
     - **An example, a person is charged with public intoxication and it's the only Alcohol related charge on their record. Is that person prohibited from employment**

   This has been addressed in the policy.

3. **#1c. Crimes of dishonesty and Moral Turpitude – I'm sure this came from code but was not in prior versions (I'd remember if I wrote that in policy!). Is this one that needs further definition?**

   This has been removed from the policy.

4. **Theft used to have a 10 year time frame from date of application – there may be employees in the system who may no longer meet the new requirements and timeframes/grandfathering implementation may need to be clarified**

   Time limits have been addressed in the policy.

5. **Delete draft, too vague, unreasonable, no timelines.**

   It probably makes more sense to have a discussion as to what is appropriate in the policy and address it that way (which is what we are doing here). Your suggestion does not offer a constructive solution to what you view as a problem.

6. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

Volunteers have been addressed in the policy.

7. **Under item 1. k., the current rule does not include misdemeanor battery charges. Will there be a "grandfathering" provision for those employees who met the current requirements, but would not meet the new policy?**

   Misdemeanor battery has been removed from the policy.

8. **It is our understanding that language will be added to item 1. l. to read "any *felony* offense relating to alcohol or a controlled substance."**

   This change has been made to the policy.

9. **Should item 1. m. also be reflected in the Documentation of Criminal Histories policy?**

   #1. m. has been removed from this policy.

10. **Under 2, as worded, we would need to run background checks on anyone we do business with including financial auditors, community members who volunteer to sit on a committee that has no client contact, and external consultants brought in to provide business expertise we cannot afford to hire on a permanent basis.**

    Agree. This has been addressed in the policy.

11. **Under 3, same number 2 above. This is a broad section of people and we cannot ensure the legal status of everyone associated with the agency. Employees, yes, others no.**

    Agree. This has been addressed in the policy.

Financial Requirements of Providers

1. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   This is not mentioned in this policy.

2. **Concerns in 1. c., does this mean an official Line of Credit must be approved or that a financial institution must certify in writing that the entity is creditworthy?**

   A financial institution must certify in writing that the entity is creditworthy.

3. **Financial Stability – the standard appears to possibly mean that the provider needs two months of operating reserves or does it mean the provider has to guarantee that they can provide services to enrolled individuals for two months?**

The provider has to guarantee they can provide services to enrolled individuals for two months. We're not sure how a provider can guarantee that they can provide services without operating reserves though. How do they keep the lights on and keep employees paid, for example?

4. **At minimum 2 months? What is the maximum amount of time? This is left open and puts providers in a financial black hole. Should we anticipate BDDS asking for 3, 4, 5 or more months of stability for non-payment? It is inappropriate to make a provider go for an extended period without reimbursement for services rendered in good faith. Great way to put a provider out of business without other cause.**

   This is the current standard and has been the standard for years. Presumably you showed this ability when you were approved as a provider. This is necessary to ensure the individuals health and safety in case of an unforeseeable emergency situation.

   Again, not one word was changed from the current standard.

Human Rights Committee (HRC)

1. **We recommend that the initial language in 1(a) should state that an HRC "shall be established", and that 1(b) not only require that the chairperson be free of the listed conflicts of interest, but that all members of the committee not have any such conflicts.**

   Ideal, but not a realistic requirement at this time

2. **The policy should set a minimum number of individuals to make up the committee, either 5 or 7 is recommended, and that further defined individuals such as persons with DD family members or DD community connections be added to the list of HRC participants. The only number of members defined in the policy comes under section (e), which requires a minimum of three (3) HRC members to participate in a meeting involving individual entitlements or rights. Also, minimum attendance standards, as well as minimum numbers of members to hold a valid vote (i.e. plurality, etc), should be more clearly defined.**

   We set the minimum at 3.

3. **The function of the committee should be more clearly stated. The policy should clearly identify the anticipated subjects and decision-making responsibilities of the committee, part of which could derive from the HRC responsibilities found for ICFs-MR in Appendix J of the State Operations Manual, and also from 42 C.F.R. § 483.440(f)(3)(i-iii). The cited appendix is somewhat vague and unclear, and would need to be better defined and written.**

   We believe we have addressed in the policy.

4. **We would also recommend considering the HRCs as a forum for individual grievances and complaints, which is currently done in some of the state operated facilities for persons with mental illness, e.g., Richmond State and Evansville State Hospitals. A clearer statement of the intended interaction between the providers, HRC and BDDS should be made as regards the reference to 460 I.A.C. § 6-10-12 cited at the end of the proposed policy. It is not clear what**

interaction and relationship is intended between the entities or their committees as a result of this reference.

We don't think we could further formalize at this time.

5. **We support the function and scope of Human Rights Committees to safeguard the rights of people receiving services. We recommend the addition of a Direct Support Professional with a minimum of two years of experience be a required member of the committee.**

   DSPs often serve as a primary advocate for the people they support. Because of the nature of providing day-to-day support, DSPs offer a unique perspective that would add value to the work of the HRC.

   We don't think it is appropriate to further prescribe to composition of the HRC at this time. However, a DSP can certainly serve on the committee.

6. **If the state intends to have HRCs function consistently throughout the state and among providers, some additional language should be included that describes the minimum components of the function (e.g., what types of issues must be reviewed, frequency of review, monitoring of plans that contain restrictions, etc.) of the HRC. Each provider having a written policy doesn't ensure consistency since there could be a wide variance in the contents of each policy.**

   These issues have been addressed in the appropriate policies. The intent of this language is to guide on the composition of a Human Rights Committee.

7. **Should there be any requirements for ongoing training for HRC members – frequency, issues, etc. to ensure that HRC members remain current in human-rights related issues?**

   It is a nice thought, but not realistic at this time.

8. **References – include the Protection of an Individual's Rights, Use of Aversive Techniques, Use of Restrictive Interventions Including Restraint, and the Behavioral Support Policies.**

   Agree. These references have been added to the policy.

9. **Delete 1.d.i - Behavioral Support Services provider as there is no funding to support this.**

   Necessary to ensure this area of expertise is represented on the committee.

10. **I believe our committee generally meets the intent of the proposed policy. However, under 1(a) of the proposed policy, the language indicates that one particular agency authorizes the establishment of the Human Rights Committee. Since this is an interagency committee, no one single entity authorized the committee; each participating agency authorized the establishment**

and participation of the entity. I would ask that the language be more general to allow the formation of multi-agency Human Rights Committees. (CIHRC)

Agree. This has been addressed in the policy.

11. **I would also ask that you review section 1 (b) as it pertains to the chairperson of the committee. With this interagency committee, the chairperson currently is often an employee from one of the participating provider agencies who is elected for a six (6) month term, but it could also be a member who is an individual with developmental disabilities. Since there are a variety of agencies and this role does not remain with one member for more than six (6) months at a time, this ensures that the role of chairperson is not favorable for any one provider agency. (CIHRC)**

The chairperson should preclude themselves if the issue involves their agency.

12. **We believe the DDRS established Human Rights Committee is no longer in existence.**

We disagree. Current members include Brian Reynolds, Randy Krieble, Christy Swango, and Cindie Vanderbur.

13. **For some agencies, particularly smaller ones, it is difficult to get someone to chair the HRC without compensation. It would be helpful if there could be some allowance for nominal compensation that preserves the objectivity and autonomy needed for the role.**

Nice thought, but not at this time.

14. **d i In rural communities it will be difficult, if not nigh impossible, to convince someone to drive over an hour to attend this meeting for FREE or are you putting this as a requirement for the BSP to be a part of the HRC for providers where the BSP has a consumer receiving services? f. The individuals who have the most information about the consumers are not allowed to participate in the deliberation which in turn will make it extremely difficult for the HRC to make an informed decision. Thereby making it more difficult to find individuals who will be willing to serve due to the potential liability risk they will incur under this policy.**

If information is presented to the HRC appropriately a decision should be able to be made.

15. **Pg.1 Item 1.b.i: Does this section exclude voluntary/community members of the Board of Directors of the Provider Entity? Are the position named all paid positions and/or contractors? This is not clear.**

As long as they are not a paid employee

16. **1f is a good policy and welcome change with the proviso; as long as the individual whose rights are being addressed and the IST are heard and able to question members and state concerns.**

Individuals or the legal rep do not have to sign and agree to the plan. The individual or legal rep could also choose to take the plan to the Team to discuss. The Team has the option to call a Team Meeting anytime.

17. **A question about the new policy draft is if a RHS provider's HRC does not approve a procedure, and another provider does approve, and the team either agrees with the other provider or is divided, where does the team go for a final decision? Will DDRS have an HRC that will be available to review the case and give an opinion? In the past I used the outreach HRC for these situations. An example, I had a case in which the individual engaged in severe physical aggression that either resulted in injury to others or put others at high risk for injury. The guardian requested physical restraint be added to the BSP. The team discussed the issue and felt it was needed. Data strongly supported the procedure. The RHS provider's policy was that they did not do physical restraints. The approach was added to the BSP with a very specific protocol to be followed. As the behavior provider it was presented to my HRC and discussed at length with a review of the data included. They approved the approach. The RHS provider's HRC requested more information which was provided but would not approve the approach. The intervention was not removed from the BSP as the guardian's request. On one occasion the individual had his mother by her hair and was pulling her around while also kicking her and attempting to grab objects with which to hit her. (He had in the past used a hoe to hit staff and on one occasion attempted to grab a police officer's revolver, so it was a severe case) The staff was standing in the door, while the mother was asking for assistance and the staff responded with "I am not allowed to touch the individual." I only give this example to demonstrate in practice it can get very complicated. Will there be an appeal HRC or is the team bound by the decision of the RHS provider if there is a difference? Also, I do know of some RHS providers who do not have an HRC. Will they be required to have one?**

    If the guardian doesn't approve of RHS providers policies, he/she may want to seek a new provider. Also see the previous answer.

18. **Finding a Chairperson who is not a part of the agency to conduct the meetings could be very difficult. Possibly utilizing someone from another department to review the HRC information and be that chairperson?**

    We understand, but we think this creates a conflict.

19. **Possibly adding examples of when HRC approvals would be necessary?**

    Restrictive Intervention policy addresses.

20. **I understand why you would want a person outside the agency to be the Chairperson for the HRC. The problem with them not being affiliated with the company is that they will be doing a great deal of work with no compensation. We have a large company and to ask someone to use their spare time to mail/e-mail/phone calls, plan, use their own money for supplies, making sure**

documentation is correct for 200 consumers. Is a great commitment for any person. We have a hard time finding people in the field to be on the committee let alone chair it. It will be hard enough to get enough people to interchange on the HRC so we do not have them making decisions on the clients they serve.

We understand your concern and this is a difficult area to address. At this time, we believe it should be composed as stated.

21. **What are the responsibilities of the Human Rights Committee for persons on the Waiver? HRC's continuously struggle with this issue. The Behavior Support Plan and Use of Restricted Interventions policies will help but does not clarify the role of the HRC or the responsibilities they have.**

    The two areas you mentioned are their main responsibilities.

22. **This policy is more stringent than information contained in the 460 standards in that this policy requires the chairperson to be a non-employee. Our Human Rights Committee has never had any difficulty with any survey process and the expertise of our chairperson is invaluable.**

    We understand, but we feel this creates a conflict.

23. **We recommend revision of the draft policy to permit continuation of interagency Human Rights Committees authorized by the executive directors of participating provider companies without restriction of affiliation of the chairperson. Experience indicates that it would be very difficult to attract a qualified unaffiliated individual to the chairperson role.**

    Agree. Interagency HRCs are acceptable.

24. **I was with you until you included this last item:**
    2. In the event of multiple Human Rights Committee reviews of an entitlement or rights issue affecting an Individual, the hierarchy of Human Rights Committees having authority is as follows, with the HRC in section "a" below having the highest authority, and the HRC in section "d" below having the lowest authority:
    a. a HRC established by DDRS;
    b. a HRC established by the Individual's Residential Habilitation Services (RHS) Provider;
    c. a HRC established by the Individual's vocational or employment services Provider;
    d. a HRC established by a Behavioral Support Services Provider.

    This may be politically advantageous for DDRS but is backwards in reality. HRCs associated with bman provider – e.g. OPG, MDS, etc. tend to be much more advocating for client rights than Res Providers. In fact, HR violations by residential providers are often addressed in the BMAN HRCs but ignored by the RES providers. In fact, I have had BMAN arranged to be fired by RES providers because the BMAN found HRC violations by the RES providers.

Agree. This has been removed from the policy.

25. **This specifies that the Human Rights Committee must include, "at least one person who meets Behavioral Support Services provider qualifications per 460 IAC 6-4.3-2;" Please clarify if this can be another employee of the provider agency, or if it must be a Behavioral Support Services provider from an outside agency. For example, if I write a Behavior support plan, can my coworker serve on the Human Rights Committee that approves/disapproves it, or does my Human Rights Committee have to consist of a Behavioral Support Services provider from another provider agency?**

    As long as they are not the chair, an employee of the provider agency is acceptable.

Imminent Danger

1. **This policy is also fairly comprehensive. We recommend that there should be a provision in the "Responsibilities upon discovery" section under which any provider or other personnel involved in the incident defined to be imminent danger is separated away from the individual. Under "Responsibilities following mitigation of imminent danger" at number 3, the pertinent BDDS/BQIS policies and policy number(s) should be clearly identified.**

    DDRS believes #2 under "Responsibilities upon Discovery" covers the recommendation of separating personnel involved in an incident of imminent danger away from the individual.

    Rather than DDRS attempting to prescribe every policy in which an imminent danger situation could occur, we will leave it to the best judgment of the entity responsible for the discovery and the subsequent follow up events to follow the appropriate policy.

2. **The Responsibilities upon Discovery is a bit different than the same section in the Incident Reporting and Management policy. Suggest the two policies be consistent.**

    We believe they are consistent. Additionally, we removed contacting the DDRS Director as that will be an internal procedure and not the responsibility of the person discovering or reporting the imminent danger situation.

3. **Responsibilities upon Discovery - We feel that this policy puts all responsibility on BQIS or BDDS staff. Residential agencies may not be able to reach one of these entities over the weekend or in the middle of the night, and need the authority to protect the individual's safety. We feel that there should be provisions for the provider agency to take steps to immediately protect a person from imminent danger, and to be able to make that determination on their own.**

    DDRS agrees with this statement and upon reading the policy with this comment in mind we have changed the wording from "BQIS or BDDS staff" to "the person making the discovery".

Additionally, along the same line of thought, #2 & #3 in the "Responsibilities following mitigation of imminent danger" have been removed.

4. **Responsibilities Upon Discovery - 3c: manager with the responsible provider company. NOTE: many times there is only a BMAN or CHIO provider, possibly only a Respite provider for some individuals on the various Waivers. These providers may have no responsibility over the reasons for imminent danger. I.E., a provider of CHIO may have no responsibility for residential or health needs but be the only provider of record.**

   What we are looking for with this statement is that the **responsible** provider company be contacted. If an individual is found in an imminent danger situation because his/her waiver home is on fire, the responsible provider company would be the residential provider. If an individual is in an imminent danger situation while doing his community habilitation activities, it would be logical to contact the community habilitation provider. Additionally, if an individual is in imminent danger and only receives behavior management and is found in an imminent danger situation, we do not view it as a bad thing that this provider is contacted in the event that this provider may be able to help mitigate the situation, even if that is outside the purview of a behavior management provider's "job".

5. **Responsibilities following mitigation of imminent danger - 3. Refers to BDDS District Manager relieving at the scene. There is no item in this policy stating that the BDDS District Manager must go to the scene.**

   This step has been removed.

Incident Reporting & Management

1. **The concept or definition of sexual abuse should be expanded to include any sexual contact, consensual or otherwise, between an individual and provider staff.**

   With the language "including but not limited to" we feel these situations would be covered when it is deemed appropriate to report them.

2. **Under "Reportable Incidents", paragraph 11, the term "emergency intervention" should be defined and examples provided for clarification as to the application of the standard.**

   We agree—"emergency intervention" is now defined within the Incident Reporting policy.

3. **In the section entitled "Initial incident reporting to BQIS" on page 4, subsection (d), line 2, the word "ho" should probably be "not".**

   This error has been corrected in the policy.

4. **Insofar as "Reportable incident follow-up" found on page 5, there should be a clearer definition under number (1) which identifies the circumstances under which BQIS may immediately close the incident upon receipt and processing.**

This is done on a discretionary basis when determined by BQIS that all criteria for closing have been met. For example, an incident was filed because the van an individual was being transported in got a flat tire. The flat tire was changed on the spot and the incident is fully addressed. BQIS would immediately close this incident.

5. **Reportable Incidents #4 – peer to peer aggression – this one has gone back and forth between every incident and any incident with injury over the years. May need clarification.**

   DDRS agrees and has changed the language to read: "peer to peer aggression that results in significant injury…" Significant injury is outlined in #14 of "Reportable Incidents".

6. **Reportable Incidents #9 – missing person – may want to add clarification that the intent here is when the person should be under supervision. (I think most assume this but cannot be too clear)**

   Allow this to serve as clarification that if a provider believes a person has gone missing, whether under supervision or otherwise it should be reported.

7. **Reportable Incidents #16 – is the intent for this to be every medication dosing error or medication errors when a physician determines risk? If this is every prescribed medication this could mean significant increases in errors due to some non-critical items such as dietary supplements prescribed by a physician would also be included.**

   This is a great point of emphasis for the Centers on Medicaid and Medicare (CMS). They have made a very strong point that we must track ALL medication dosing errors, not just errors when a physician determines risk. We realize this is a change from current policy and that it will cause an increase in medication errors reported as incidents, but CMS is requiring this of us.

8. **Effective date of this policy? Providers will need adequate time to train staff on the changes.**

   The effective date of this policy will be March 1st. There is a training scheduled for February 15th, 2011. This will allow time for providers to adapt to the new policy and train staff on the changes.

9. **Will FAQs be available for this policy?**

   FAQs are being developed by BQIS and their vendor.

10. **Reportable Incidents – #1.c. – change wording to emotional/verbal abuse instead of verbal/psychological so it will be consistent with the language currently being used.**

    We agree and this change has been made to the policy.

11. **Reportable Incidents #2.a. – change wording to appropriate supervision or care (not training).**

    Care has been added to the policy – training will remain as well.

12. **Reportable Incidents #14.c. – add iii. back blows.**

Agree. Back blows have been added to the policy.

13. **Reportable Incidents #16.d. – remove the word "and". It is not used for any of the other listings in this policy. Do not want to give the false impression that items a-d are only reportable if e is true.**

    Agree. This change has been made to the policy.

14. **Ensuring the safety of individuals receiving services – would suggest including the wording from 460 regulations regarding the requirement to remove staff from duty pending the outcome of the investigation related to an allegation of abuse, neglect or exploitation. This does not always occur. If it is specifically stated in this policy, it will be front and center.**

    We have tied the responsibility of mitigating these instances to the process outlined in the "Imminent Danger" policy. This should be done in accordance with that policy and 460 IAC 6.

15. **Initial incident reporting to BQIS – item 2.e. – add phrase 'and staff title if applicable' prior to 'of each person involved'. In addition, the full name of another consumer should not be used in another person's IR.**

    Agree, the following language change was made to the policy: "a listing of each person (first name, last initial) involved in the incident, with a description of the role (and staff title if applicable) of each person involved."

16. **Page 9, Agency Submitted Report – revise to Submitting**

    Agree. This change has been made to the policy.

17. **Could you define "mandated reporter" in the policy definitions**

    Yes, this definition has been added to the policy definitions.

18. **Reportable Incidents #14. b. – I would put j under b to read: "A burn, including sunburn and scalding, greater than first degree." Scalding is a burn and usually much worse than 1st degree.**

    Agree. 14. j. was removed and moved to 14. b.

19. **Reportable Incidents #1. a.i – add by staff. Also, "rude, insolent, or angry manner" is vague/not descriptive .**

    Staff are included in the phrase "another person" since they are people too.
    A "rude, insolent or angry manner" is language taken straight from Indiana Criminal Code (IC 35-42-2-1). It is one of those things that we don't feel should be prescribed because then it becomes gospel. It is one of those situations that is best described as "you know it when you see it". Please use common, human judgment.

20. **Reportable Incidents - 3b – Remove; could be all incidents**

    This is very concerning to hear. This comment essentially says that every individual is being exploited for the profit of another? DDRS is not really sure how to respond to this comment?

21. **Reportable Incidents #15 – Limit reporting to falls that result in injury as defined in #14**

    CMS has urged us to track all incidents involving falls regardless of the nature.

22. **Ensuring Safety of Individuals Receiving Services #1.c. - Unclear as to when to contact the following?**

    Clarified in policy that the process outlined in the "Imminent Danger" policy is to be used and hopefully common sense will prevail.

23. **Reportable Incidents #1.a.vi. - Need contact information for Director of DDRS**

    This has been removed. This should be the responsibility of BDDS staff and is an internal procedure.

24. **Reportable Incidents #2 - Not consistent with Imminent Danger policy**

    It is consistent with Imminent Danger policy as written now.

25. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

    We see no mention of this in this particular policy, but these different positions must follow the incident reporting policy.

26. **16. A medication error or medical treatment error as follows: Define medication given wrong route?**

    An example would be a doctor prescribes the medication to be given orally and it is given rectally instead.

27. **Reportable Incidents #14 – "Significant Injury to an individual that includes, but is not limited to: d. bruises or contusions larger than three inches in any direction, or a pattern of bruises or contusions regardless of size; and h. any puncture wound penetrating the skin" – Both of these definitions of significant injury are too broad, encompassing many injuries that could be minor in nature.**

    This is another area we do not feel we should be overly prescriptive. This also falls under the "you know it when you see it" category. All we are asking is to use good judgment.

28. **Reportable Incidents #19 – The change to this wording from the previous "injury that occurs while an individual is restrained" significantly changes the intent of the reporting. If the provider is following all regulations and policies related to use of restraints and has had the restraint planned with the approval of the IST, Human Rights Committee, and informed consent by the individual**

provided services and/or legal representative there should be no reason why BQIS would need to individually review every restraint. If an injury occurs due to restraint it is logical to review the procedure to insure the client is not in danger, but reviewing every restraint appears unnecessary.

CMS was very concerned that we were allowing the use of restraints at all and informed us that in order to continue this practice we must report all incidents involving the use of restraint regardless of the severity.

29. **Many agencies, including us, are moving away from the title QMRP to QDDP. Is this being considered for policy?**

    DDRS supports this change and will make the appropriate edit throughout our policies.

30. **Reportable Incidents #1 – This section differs from 460 IAC 6-3-2. I would recommend in align with the rule. Also, 1c.v states "cause the individual to react in a negative manor." This is very vague and an individual could "react in a negative manner" from a staff person running the behavior plan correctly or from many other things. This could lead to multiple, un-necessary investigations and suspensions of staff.**

    We find it hard to believe that any BSP would include emotional or verbal abuse as addressed in this section. If this is the case there probably needs to be a separate conversation.

31. **Reportable Incidents #19 – We recommend that this be changed to "Use of any chemical or mechanical restraint". Reporting any/all physical restraint regardless of planning, human rights committee approval, and informed consent for individuals with known psychiatric diagnoses such as Impulse Control Disorder, Intermittent Explosive Disorder, Post Traumatic Stress Disorder, Schizophrenia and Other Psychotic Disorders goes beyond reasonable reporting. Individuals with some of these dual diagnoses cycle through symptoms and behaviors that are typically well known and may require multiple brief physical interventions to maintain safety as individuals stabilize. Requiring staff to make a report to the state for each and every physical intervention essentially eliminates the distinction between unknown/unexpected emergency interventions and known individually prescribed interventions. It imposes an enormous reporting burden to providers who support the very chronically mentally ill.**

    Number 18 of the same section covers reportable chemical restraints, so no need to address in #19. As addressed earlier, CMS considers the use of restraints to be an antiquated practice and is requiring we report every instance involving the use of restraints.

32. **Responsible Parties #1 – Provider responsible at time of incident. For clients living at home, or for clients with only CHIO, Respite, etc, there may not be a provider responsible at the time. This leaves the only provider of record responsible for the report, which must be stated and the information must get to them in order to report. For clients living at home with intermittent services, this leaves quite a burden on a provider who may have no direct responsibility.**

    We understand the concern, but we also feel providers take on a level of responsibility when they choose to care for the developmentally disabled population and accept Medicaid dollars in doing so.

33. **This policy seems to have gotten so extensive. Why not keep the current system and policy?**

    This has been addressed already, but will be re-emphasized here: CMS is requiring many of these changes. But beyond that this really goes to the concern of the health and safety of individuals receiving waiver services and doing what is in their best interest.

34. **In the statement requires medical evaluation or treatment. What does that mean? Agency nurse evaluation, doctor appointment, or ER? - #13. Any injury to an individual when the cause of the injury is unknown and the injury require medical evaluation or treatment.**

    Yes, all of the above. Any licensed medical professional.

35. **Reportable Incidents #2 - More things will be reported to APS/CPS as the definition of abuse, neglect and exploitation has been broadened. Was this your intent?**

    If these are appropriate situations in which APS/CPS should be contacted, then yes this is our intent. The health and safety of the individuals we serve must be preserved to the highest level.

36. **Suggest this be included in the incident reporting policy. Rarely, if at all, would BQIS or BDDS be first on the scene to call 911. This policy as a standalone is confusing; it would better follow a section in the incident reporting policy where the imminent danger policy is referenced.**

    We agree. This change has been addressed in both the incident reporting policy and the imminent danger policy.

37. **The draft policy represents additions to the types of incidents for which reports must be filed currently. Further clarification could preserve the intent of the draft language without creating an onerous paperwork burden. In this regard, we recommend exclusion of the reporting requirement for incidents of consumer to consumer verbal/psychological abuse (1.c.) targeted under an approved behavioral support plan. Similarly, we recommend exclusion of the reporting requirement for the use of physical or manual restraint when it is applied for a behavior(s) targeted under an approved behavioral support plan. Alternatively, for individuals who are in crisis and require repeated applications of physical or manual restraint, the reporting requirement should permit grouping of incidents on one report. Finally, it is recommended that the term "physical or manual restraint" should be defined within the policy to exclude procedures such as physical prompting, graduated guidance, and brief restriction of the movement of limbs to limit the harm posed by physical aggression, self-injurious behavior, and/or costly destruction of property.**

    In the year 2011, the use of restraints and other restrictive interventions is seen as antiquated practice. CMS is intently monitoring this and thus has required us to report these incidents.

Individual/Guardian Responsibilities While Receiving Waiver Funded Services

1. **There is concern with the section specifying "Consequences for Non-Participation". The policy states that should the individual not follow the requirements (listed one through four), BDDS may**

give written notice of intent to terminate the individual's waiver services to the individual. The word "may" is quite ambiguous in this context, as it is unclear on whether BDDS may give written notice or BDDS may terminate the waiver services. If BDDS terminates services, written notice should definitely be required. As such, this section may be better written, and less ambiguous, as:

Should an individual (or their legal representative when indicated) choose to:

1. **not share information as described in this policy; and/or**
2. **not complete actions necessary for changing providers as described in this policy; and/or**
3. **not participate in risk plan development and implementation as described in this policy; and/or**
4. **not allow representatives of the state into the individual's home as described in this policy,**

BDDS may terminate the individual's waiver services. If BDDS decides to terminate the individual's waiver services pursuant to this policy, BDDS must provide written notice of intent to terminate the individual's waiver services to the individual (or the individual's legal representative when indicated).

We agree with the language change to better convey the intent and have made the change in the policy.

2. **Additionally, other proposed policies define "DDRS" when used; this policy fails to do so. For purposes of uniformity, DDRS should be defined here, as well.**

   Agree. This was an oversight and the change has been made to the policy.

3. **If guardian appears to be uncooperative, the state agency may terminate Waiver services. Is this permissible?**

   Yes. Waiver services are not an entitlement program and users, or their legal guardian agrees to comply with rules upon acceptance of the waiver.

4. **Under section "Appeal Option", wouldn't the individual also have appeal rights as detailed on the Notice of Action that terminates their services?**

   Yes. Change has been made to the policy.

5. **Consequences for Non-Participation - Where it states "BDDS may give written notice of intent to terminate the individual's waiver services to the individual (or the individual's legal representative when indicated)", we feel there needs to be a list of steps that can be taken by the provider agency if an individual or guardian is uncooperative, and if BDDS does not decide to terminate their waiver. The provider agency should be given the option to discontinue services once their notification timeline is complete.**

Providers still have the 60-day termination option.

6. **Changing Providers: 60 day notice. How will this be enforced?**

   This is one of the main points of the policy. The provider will be removed from the individuals CCB and we will work with the individual or their guardian to change providers. If they refuse to cooperate we take action as noted in the "Consequences for Non-Participation" section.

7. **Allowing Representatives of the State into the individual's home - 72 day notice is not adequate. Is there going be flexibility with families? I think a 10 day notice provides more flexibility with the family's schedule.**

   We feel this is an adequate timeframe.

8. **Define "other purposes as determined necessary by BDDS or BQIS". This means that BDDS or BQIS can come into the family's home at any time for any reason. What if the reason is not determined warranted by the family?**

   Medicaid waiver funded purposes only, as highlighted in the policy statement.

9. **If Case Managers are responsible for managing services for the individuals why would there be a need for the State to visit the family home. If case managers are meeting with individuals quarterly wouldn't these policies indicate a lack of adequate oversight/monitoring of the individual/family/services?**

   BDDS or BQIS are often made aware of unfit situations happening in a home. In these instances we feel it is absolutely necessary to have someone visit the home immediately to ensure the individual's health and safety.

10. **We have never seen a "risk non-agreement document" offered to a guardian**

    Correct. This is new and will be outlined in the forthcoming Risk Management policy.

11. ***Regarding changing providers.*** **The language is quite specific about the Legal Representative's requirement to act in a manner that supports a 60-day window to accomplish a change in providers. Is the current provider required to continue to provide services (health & safety) to the individual should the change require more than 60-days? I assume so, and that the policy attempts to establish a performance obligation for the Legal Rep without allowing the provider to abandon the Consumer, but want to clarify.**

    Yes.

Individuals' Personal Information: Provider Office

1. **The policy references HIPAA compliance regarding information stored in electronic format and defines HIPAA in the definition section, however, never makes a general HIPAA compliance requirement for the individual's personal information. It is important that the individual's personal information is adequately protected; adding HIPAA compliance language to this policy would help ensure that goal is being met.**

   The change has been made in all policies to include all formats. A HIPAA-specific policy will be forthcoming.

2. **Additionally, "developmental disabilities waiver ombudsman" is listed in the definition section of this policy, yet no definition is provided. This term needs to be defined.**

   Agree. This oversight has been corrected in the policy.

3. **Finally, the citation reference "460 IAC 6-4.19.4" listed in section 5(f) of the policy does not direct to a proper Indiana Administrative Code section. This section of the policy needs to be corrected to direct to the proper administrative code.**

   Agree. Change has been made in the policy.

4. **Delete 2-4 Providers will comply with having the data and the documentation; the provider should decide how the data is kept.**

   We respectfully disagree. Too many providers were in violation.

5. **5. c. i and iv –viii – delete. Do not need. Does not add value. Adds more work.**

   We disagree. Anyone should be able to pick up an individual's folder and have all of this information readily available.

6. **#5. n. – add if the provider is the payee.**

   Agree. Added representative payee to the policy.

7. **#5: Policy states that the individual's personal information at the provider's office should include "c. Telephone numbers for emergency services that may be required by the Individual to include at minimum: i. the local emergency number, for example 911; iv. The local BDDS office; vi. Adult Protective Services or Child Protection Services as applicable; vii. The developmental disabilities waiver ombudsman." This requirement for the files located at the provider's office is not listed in the 460 IAC 6. These phone numbers would be duplicated through all clients and would be very repetitive to list in each file.**

Our recommendation is to make one list and put a copy in each individuals file for these numbers. As we said earlier, anyone should be able to pick up an individual's file and have all of this information readily available.

8. **Many documents listed under Section 5 are not identified in the list of required documents for the Provider's office found in 460 IAC 6-17-4, one such example of a document not required at the provider's office by 460 IAC 6, but listed in the DDRS policy: "d. Consent by the Individual or the Individual's Legal representative for emergency treatment for the individual." This consent is required to be at the site of service by 460 IAC 6, but there is no mention of it in relation to the provider's office file.**

   This discrepancy will be addressed in the update of 460 IAC 6, but for now the DDRS policy directive should be followed.

9. **#5. f. – "Systems outlined in 460 IAC 6-4.19.4, as indicated for the Individual." - When reviewing 460 IAC 6 we found no section numbered as stated this way. I found 460 IAC 6-4-1 (19) which just states "Prevocational services," but there is no "System" as called for in this section of the DDRS Policy.**

   Agree. Change has been made to the policy. This was meant to be a reference to Health Care Coordination.

10. **#5 - p. – "A listing of all adaptive equipment used by the Individual that includes contact information for the person or Entity responsible for replacement or repair of each piece of adaptive equipment." – All adaptive equipment is listed in the ISP document. I found no mention of this additional list in 460 IAC 6. (This document is also listed in the DDRS policy for Individual Personal Information at the Site of Service Delivery and once again I found no reference to this in any other regulation and am unsure of the relevance of maintaining this document for all clients)**

    It is important to remember that some of the information in these new policies is not necessarily in 460 IAC 6, but it is part of a larger picture. 460 will be going through the promulgation process soon and these changes will be addressed.

11. **Under 2. (a), it would be useful to clarify the term *any electronic format or system*. Are we speaking specifically regarding document management systems, or is the term being applied loosely to include anything electronic, including digital photos, databases, electronic forms, word and excel documents, etc.**

    The latter interpretation is correct. This language is being used loosely to mean ANYTHING electronic, including the items listed.

12. **Under 2. (a) (ii), No system can ensure compliance with HIPAA. Systems can only allow providers to set up rules for compliance**

    We feel the intent of this language is clear.

13. **Under 2. (b) (i), *Permanent.* Keeping all entries of all types into the electronic format or system is excessive. Over time this will create a burden on systems. Electronic information should follow the same retention policies as non-electronic information.**

    This is not intended to be permanent as in "forever". This is intended to be permanent as in, "not able to edit".

14. **PCP should be a required document.**

    While there is an "outline" case managers keep track of, the Person Centered Plan (PCP) is really more of a philosophy used to guide the development of an individual's Individualized Support Plan (ISP).

Individuals' Personal Information: Site of Service Delivery

1. **The policy defines HIPAA in the definition section, however, never makes a general HIPAA compliance requirement for the individual's personal information. It is important that the individual's personal information is adequately protected; adding HIPAA compliance language to this policy would help ensure that goal is being met.**

   Made change to the policy to include all formats. A general HIPAA policy will be forthcoming.

2. **Additionally, "developmental disabilities waiver ombudsman" is listed in the definition section of this policy, yet no definition is provided. This term needs to be defined.**

   Agree. This oversight has been corrected in the policy.

3. **Finally, the citation reference "460 IAC 6-4.19.4" listed in section 2(e) of the policy does not direct to a proper Indiana Administrative Code section. This section of the policy needs to be corrected to direct to the proper administrative code.**

   Agree. Change has been made to the policy.

4. **My only clarifying question here goes back to the BQIS Complaint policy – should that contact number be included on the phone listing?**

   Provider should keep the number generally available, and we certainly won't restrict its inclusion.

5. **In reference to any item requiring that documentation from the previous two months, is this to be interpreted the current month plus the previous two months or the current month plus the past month?**

The intent is the most recent 60 days as should be currently happening. This language change has been made in the policy.

6. **Site of Service Delivery #2. b – A photograph of the individual is a real problem for us as approximately half of the individuals we serve are of the Amish faith which views pictures as a Graven Image and violates their faith to require one be taken and placed in their file.**

   We feel this is necessary in order to ensure the health and safety of these individuals.

7. **#2. g – Copies of medical, dental and vision services summary documentation: When the family has been identified in the ISP as responsible party for medical, dental, and vision will they be required to keep information at the site of delivery and provider office?**

   Yes. Necessary to ensure health and safety.

8. **#2.g. – We are a little unclear of what is expected here. We currently have the past 2 months' monthly summaries in the home which includes a summary of all medical appointments and outcomes. I hope the intention of this statement is not to have the copies of the original documents from the appointments also in the home. This would be another prime example of an inefficiency that would be required of us.**

   We feel it is very important to have this information readily available in the case of an emergency. As an example, if an individual should have to go to an ER in an ambulance, someone should be able to provide this vital information so the doctors at the hospital can provide the best care possible.

9. **#2.n. – Having the client's checkbook in the home for some consumers would not be wise. This can create the increased risk for exploitation and some consumers may not be able to control their spending. Can a statement "unless otherwise noted in the ISP" or something along those lines be added?**

   This information should be locked.

10. **#3 – Clarification that "allows for review at the time a verbal or written request is made" includes review by electronic means from the site of service delivery.**

    Yes, as long as it is available immediately. The response of "our data person is out until Monday" will not be accepted.

11. **#2.g. – This information may not be relevant to FHG, CHIO providers. That is a lot of personal medical information that does not need to be in a Day Service file.**

The same applies here as applies in the answer to #8 above.

12. **2.j. – All MAR forms for the previous 2 months. Even if no medications are administered at the Day Service? Once again, that is personal information that may not be relevant and should not be in the Day service file.**

    Should at least have MAR in case of a hospital visit or if there is an emergency it could be important for a provider to know what meds an individual is to be on.

13. **#2. n. – Same as above.**

    Not applicable for non-residential provider unless they act as rep payee. Language has been added to the policy to reflect this distinction.

14. **PCP should be a required document.**

    While there is an "outline" case managers keep track of, the Person Centered Plan (PCP) is really more of a philosophy used to guide the development of an individual's Individualized Support Plan (ISP).

Individualized Support Team

1. **There is concern with the seventy-two (72) hour notice requirement for an Individualized Support Team (IST) meeting. The policy states that an IST meeting can address health, safety, welfare, behavioral, training or other needs of the individual. If the IST meeting is called to address health, safety or welfare, in particular, seventy-two hour notice may be placing the individual at risk due to the delay required for in this policy. As such, the policy should make an exception for at least health, safety and welfare circumstances. Alternatively, the policy could make an exception for emergency IST meetings which would not require the seventy-two hour notice.**

   Agree. A change to the language in this policy has been made to reflect this.

2. **#9 Requires 72 hours notice prior to an IST meeting, yet under the Policy on Use of Restrictive Interventions Including Restraints, under the heading Use of Restrictive Interventions in a behavioral emergency it states under 1 e in case of a behavioral emergency an IST meeting shall be convened as soon as possible but not later than 2 business days which is 48 hours not 72? It would appear that these two policies conflict with one another.**

   BSP policy has been updated to say 72 hours unless an emergency.

3. **Resolution of disputes: In many cases BDDS is brought into a dispute prior to 15 days. Is this policy going to eliminate those cases making BDDS's involvement a last resort?**

Yes. The case manager will now be the front line for resolution.

4. **Individualized Support Team Meeting #6. – As a provider we would love to receive minutes from the team meeting in a timely fashion. Currently we do not receive minutes at all so the timeline of 48 weekday hours may not be realistic and the case managers may need a little additional time to complete these. How is this enforced and what can be done for repeated offenses?**

   This is a good point. We will re-emphasize to case managers. If a case manager is not complying please report it to the BDDS District Manager for resolution.

5. **Individualized Support Team Meeting #8 – The majority of hours of care provided must be represented. Is this to read the provider of the majority hours of care?**

   No. The majority hours of an individual's care must be provided. For example, if 40% of an individual's care is designated to residential habilitation, a meeting cannot be held with just the res hab provider present. If behavior management constitutes another 15% of an individual's care then the res hab and BMAN providers could be present and a meeting could be held.

6. **#5 and 6 under Resolution of Disputes seems redundant as the CM is a member of the IST.**

   Case manager is really viewed as the leader and facilitator of the team. This should be the frontline for resolution.

7. **CM or other note taker to provide meeting documentation to team members (#6) would be a big change.**

   Maybe, but we believe this is a good change.

Insurance Requirements of Providers

1. **We understand that is the intent of DDRS to revise this policy, so that the limits of liability are aligned with current requirements.**

   The policy on Insurance requirements for providers has been revised and the liability limits that were written in the draft have been removed. We apologize for the confusion this caused, it was never intended to go beyond the current requirements, but rather it was a miscommunication on the part of the author of the document.

Outcome Attainment

This policy is being withheld until documentation standards and requirements have been resolved and communicated.

Personnel Policies and Manuals

1. **The citation reference "6-14-5.2" listed in section 2(m) of the policy does not direct to a proper section, whether Indiana Code or Indiana Administrative Code. Likely, this citation is in reference to a particular section of 460 IAC 6-14. Whichever section it is referencing, the policy needs to be corrected so that a proper legal citation is provided.**

   Agree. The change has been made to the policy.

2. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   We disagree and believe it is applicable in this particular policy.

3. **Operations manual- delete as over done , no value**

   This is a current requirement for approval as a provider, so this manual should currently exist.

4. **Throughout many of these policies, when referring to employees, the words "Owner's, Director's, Officer's, employee's, contractor's subcontractor's, or agent's" is used. As a non-profit agency with a volunteer Board of Directors, we feel that much of this information should not apply to them. Information, such as TB test, CPR and First Aid certification, and trainings that apply to Direct Support Professionals should not apply to them. They are given manuals and training by the Director when they are appointed to the Board, but trainings are not documented as they are volunteering their time and are not employees. Also, employees such as the bookkeeper, Director, and secretary do not work with the consumers so we feel that requiring CPR and First Aid certification, and trainings that apply to Direct Support Professionals should not apply to them as well.**

   We have never required CPR for anyone who does not "work with individuals", including this new policy.

   The TB Test requirements have been addressed.

   We believe everything else is okay as currently written.

5. **#2b – Again misdemeanors and offenses of alcohol/control substances is too restrictive.**

   Agree. This has been addressed in this policy and the others affected by this language.

6. **#2d. – We conduct drug screening with limited position i.e. bus driver as a random selection. Are we being required to complete drug screening across all employees. Again, this is restrictive and costly to providers.**

   This language is intended to mean: if an employee is exhibiting behavior that leads the employer to think they are drunk, high, etc. the provider can and should address the situation.

7. **#2.l. – What is the definition of competency based in-service training and what is the expectation for documentation of such?**

   "Competency based training" means the learning of taught concepts must be demonstrated through acceptable, observable performance (whether in role playing, or in real time settings when possible,) in addition to passing a written post-test based on the training curriculum.

   Competency Based Training is measured and documented by the trainer who is responsible for teaching toward the specific consumer outcomes.

8. **#2.m. – This also needs defined including what is expected for documentation.**

   See above answer.

9. **Our agency has compiled all of this information into an on-line Knowledge Base. Please specify that having this in an accessible electronic format is acceptable. During our agency's recent CERT survey, we made this fully accessible to the surveyor who could find what she needed as any employee of the agency is able to do.**

   This is acceptable.

10. **This suggests an actual "manual". Many of us have electronic policies and procedures or utilize alternative formats. Is an actual "manual" required?**

    Electronic is fine as long as it is accessible by all employees.

11. **#2 – The documentation for training seems over done. For example; having to specify on the actual training document for each staff the qualifications of the trainer rather than just their name and the start and stop time rather than duration of the training. Is this really that necessary to prove staff received the training.**

    This is to ensure qualified, relevant training is occurring.

12. **This policy references distribution and application to "contractors, subcontractors, and agents" (in addition to owners, directors, officers, employees) – I think the contractor, sub, and agent concept needs to be formally defined – does that mean ANY contractor we work with – like Industrial**

Contractor, the Vendair Vending machine person, the floor cleaners we outsource to – or is that only for individuals (like temps) who work with clients. Also, sharing personnel policies and manuals with temps and agents INFERS they are "employees" which can be problematic when trying to determine the status of employee vs. independent contractor with the IRS

It is not intended to mean ANY contractor you work with, specifically examples like the one's provided in the question. This has been clarified in the policy.

Personnel Records

1. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   We have made adjustments in policies as appropriate.

2. **Under item 2.a., it appears this is requiring a 2-step tuberculosis test. Was this the intent? If so, what additional value would this bring to the employee screening process in light of the additional expense related to the test?**

   There will not be a requirement for a 2-step tuberculosis test. This change has been made to the policy.

3. **As written, this would require a negative TB screening for our contractors. This includes insurance agents, financial auditors, and others who are not employed by the organization.**

   The policy has been updated to reflect this requirement is only for employees, volunteers, etc. that have contact with clients. This doesn't necessarily only mean Direct Support Professional Staff, but anyone who has contact. This could mean a business office that works with an individual on his/her finances or other related situations.

4. **Training documentation (2 (f)) in our agency is kept in a training binder which we can access based on our electronic database to show what someone has completed. This allows us to keep 1 sheet of paper showing the needed information for up to 17 people rather than 17 different pieces of paper. This saves paper and helps us keep space devoted to files reduced by a small amount.**

   This is great as long as it complies with the "Provider Policies and Manuals" policy.

Professional Qualifications and Requirements

1. **We recommend that the phrase "… under this article" on page 1, 1.c. be revised to clearly state what specific item is being referenced. It is unclear as to what "article" the policy is referring to, e.g., is it another policy, state statue or the administrative code.**

Agree. Language has been changed in the policy.

2. **We also recommend that the word "Provider" on page 1, 3. be defined. The use in the policy implies reference to an agency, but having a "Provider" receive training yearly is incongruent with the concept of entity vs. an individual. Typically individuals are trained, not businesses.**

   We agree with your assessment. This has been addressed in the policy.

3. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   This has been addressed where applicable in the policy.

4. **#3 …at minimum <u>annual</u> training in the protection of Individual's rights including "c. implementing Person centered planning and an Individual's ISP;" and "d. communicating successfully with an Individual." - The 460 does not specify "annual" training for this specific training curriculum, so this is more restrictive. BQIS Provider surveys have required annual training for some trainings, but these two were not included. These were considered to be ok if one training occurred during orientation.**

   Agree. This change has been made in the policy.

5. **As listed above, we feel the use of the language "Owner's, Director's, Officer's, employee's, contractor's subcontractor's, or agent's" regarding initial and annual training in Rights, abuse, respect, PCP/ISP, Communication, and Incident Reporting would not apply to board members, secretaries, bookkeepers, and directors. We feel that it only applies to QDDP's and Direct Support Professionals.**

   We have changed the language to narrow this requirement to any of these positions that perform any management, administrative or direct service to an Individual on behalf of a Provider company.

6. **Also, under 3 – e – iii, it states that all "Owner's, Director's, Officer's, employee's, contractor's subcontractor's, or agent's" need to be trained on the BQIS internet website. We feel that it is only necessary for the individuals at the agency responsible for electronically submitting the reports to be trained on that information. At our agency, we would not be able to ensure reports were submitted to the state in a timely manner if our Direct Support Professionals electronically submitted them. Training them on how to do this would only result in confusion.**

   Everyone should be trained in this. If a DSP is afraid to do this at work via his/her supervisor, they should have the knowledge to be able to do this at home or elsewhere.

Protection of Individual Rights

1. **In regards to the definition of exploitation, Ind. Code § 35-46-1-1 does not establish an exploitation crime, rather it defines the term "dependent". We believe that the citation should be to Ind. Code § 35-46-1-12.**

   This code cite is currently listed in the policy. We are unclear of the question or confusion.

2. **We also suggest incorporating the criminal definition of neglect of a dependent, Ind. Code § 35-46-1-4 into this section. In this regard, IPAS suggests adding a section 4(f) stating "Engaging in neglect as defined by Ind. Code § 35-46-1-4."**

   Agree. We added IC 35-46-1-4 to the references for situations of neglect.

3. **Include a statement regarding staff training (or reference a Staff Training Policy)**

   This is in the "Professional Qualifications" policy.

4. **Need to include a statement that if any of these practices occur, a reportable incident report must be submitted.**

   This is outlined in the "Incident Reporting and Management" policy

5. **References – include Incident Reporting and Management Policy, Human Rights Committee Policy, and Aversive Techniques Policy.**

   Agree. Policy updated.

6. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   We do not feel that anyone, including owners, directors, etc. should be able to violate an individual's rights. It is upsetting that anyone would attempt to preclude themselves or others in a supervisory role from this requirement.

7. **#2 – With the potential changes in Medicaid coverage if services such as dental, vision, podiatry, chiropractic and hearing aides are eliminated if a individual or guardian wants them to continue receiving these services who will be responsible to pay if not them? State line item?**

   That is certainly not the intention. We've taken out the statement regarding the ISP and interpret misappropriation of funds as using an individual's funds to pay for a waiver service or something not needed or used by the individual.

8. **#2. – If the individual's family wants to pay for services over and above what is reimbursed through waiver or state line funds, I'm assuming this is allowable as the individual's funds are not be used?**

   Certainly an individual's family can opt to pay for more services

9. **#4.b. – We strongly encourage DDRS personnel to reconsider this prohibition. As discussed in a call with Becky Selig, the use of a quiet room is much safer for an individual and the staff than the use of a physical restraint. We support the implementation of specific guidelines for the use of the room: it must be in an approved BSP, which outlines when the quiet room is to be used, what must be done before quiet room is used, the person is under constant visual supervision by staff, the criteria for when the person should exit the room, etc. We encourage you to refer to W291 in the ISDH regulations which allows for the use of a time out room, including preventing exit, as long as specific criteria are met. Why must we continue to have different regulations for different funded programs? We ask that you weigh the risk of injury to the individual by the use of a physical restraint vs. the use of a quiet room which would include preventing exit until the person is calm. We would be happy to have further discussions with DDRS staff regarding this issue.**

   The policy has been realigned with the "Aversive Techniques" policy, but the federal government is moving away from these types of techniques. The ICF/MR regulations referenced above were written three decades ago and are outdated. Why shouldn't we strive beyond those antiquated expectations?

10. **#4.e.iii. – How do we prove or document that "an individual desires to perform volunteer work in the community". We think this is an important thing to allow individuals to do but have always worried about someone questioning if this would be exploitation.**

    It should be in the ISP. If it is not and you believe it should be discuss it with the Team.

11. **#2 – Misappropriation of an Individuals funds- need further clarification on meaning of this wording -any service encompassed in a person's ISP could involve everything from not allowing families who are on the wait list to pay for certain day services to asking providers to pay for art classes, boy scout fees, gym memberships to vacations etc. that are all a part of a person ISP?**

    Agree. As stated above, we have addressed this in the policy.

Provider Code of Ethics

1. **The policy states the following on page 2:**

   10. A Provider shall notify the appropriate party of any unprofessional conduct that may jeopardize an individual's safety or influence the individual or individual's representative in any decision making process, which may include:

a. the Division of Disability and Rehabilitative Services;
b. the Indiana State Department of Health;
c. a licensing authority;
d. an accrediting agency;
e. an employer; and
f. the office of the Indiana Attorney General, Consumer Protection Division;

A provision should be made in this section for guardian notification as any unprofessional conduct that may jeopardize a person's safety or influence the individual also needs to be reported to the guardian.

Agree. Policy has been updated to reflect this change.

2. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   We feel this is necessary in this case. All of these individuals are subject to ethical scrutiny.

3. **Policy and Procedure for Code of Ethics – Delete *2. a. iii- vi and b, not reasonable.**

   We disagree. These are necessary provisions to prevent unethical enticement or incentivizing of individuals to come to or stay with a provider.

4. **Under items 5. and 6., how is this reported, reviewed and enforced. We understand it is part of Article 6 currently, but shouldn't we attempt to improve it?**

   We don't think there is any argument that these actions could be viewed as unethical, but we also understand that these activities are very difficult to monitor and act upon. With that being said, we feel they should remain part of the "Code of Ethics" policy providers live by.

   Currently these actions are reported to BQIS acted upon if appropriate. We would welcome suggestions on how to improve monitoring these unethical actions.

5. **Items 9. and 10. appear to be "whistle blower" provisions of current accounting standards.**

   We do not see the connection to accounting standards, but we do agree that this is redundant whistleblower language. We will take the suggestion from the "Whistleblower" policy feedback to include those standards in the "Code of Ethics" policy.

6. **If annual audits are required, wouldn't this be addressed as part of that auditing process?**

   Don't understand the line of thought here.

7. **You state that providers cannot give gifts. Can employees of providers <u>accept</u> gifts?**

Not from providers.

Provider Conflict of Interest

1. **This policy provides the specificity needed by providers to understand the specifics of a conflict of interest.**

   Thank you.

2. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

   We are very concerned about the continued comment regarding owners, directors, etc. Why wouldn't these positions be held to a conflict of interest standard? Is this something we should focus on more? What type of behavior is happening at the top of agencies?

3. **This statement appears to be too generic and broad. What specific conflict of interest are we attempting to cover and in what types of situations?**

   We feel the definition of "Conflict of Interest" in this policy covers it.

4. **Does the term "provider" also include IPMG, Behavior companies, Guardianship agencies? It should apply to all types of companies who provider services for individuals in the Waiver program.**

   There is conflict of interest language in all state contracts, including IPMG's. The other entities you mention are providers, so yes.

Provider Organizational Chart

1. **In the "Detailed Policy Statement" on page 1, number 2.b. the word "familiar" appears to be misspelled. Based on the language in number 1.b. of the same section, the correct word is "familial".**

   Agree. This change has been made to the policy.

Quality Assurance and Quality Improvement System

1. **This policy provides for important internal provider monitoring procedures. Although the detailed policy statement, page 1, 2a calls for measuring individual satisfaction, the state should consider adding involved family for receipt of a satisfaction survey. This would provide an important perspective on how family members who provide support other than the guardian view services.**

   Parents are welcome to request and complete a satisfaction survey.

2. **Secondly, although an ISP is written to meet the needs of the individual, it could be beneficial for the state to develop provider guidelines that require specific data and methods of analyzing the collected information on ISPs as is required in this policy for reportable incidents, medication errors and tracking targeted behaviors. Analyzing ISP data could provide the state with factors that constitute successful ISPs that actually are working and meet individual needs. This information could be shared with providers who need to improve in writing successful ISPs for their clients.**

   We agree and would like to address in the future in 460 IAC 7 and associated policies.

3. **#2g – add an's' to Supports or change 'are' to 'is'.**

   Agree. Change made to the policy.

4. **#2g – include "v. training staff on behavioral supports".**

   Agree. Change made to the policy.

5. **References – include the Incident Reporting and Management Policy and the Behavioral Supports Policy.**

   Agree. Change made to the policy.

6. **Under item 2. d., who is completing the assessment of the appropriateness and effectiveness of each outcome included in the ISP?**

   Case Manager and Individualized Support Team

   a. **Should this be pared down to just include the outcomes associated with the given provider? If not, it seems this would be more appropriate for the Case Manager (CM) who is monitoring the overall ISP? Also, as the CM is responsible for writing and updating the ISP, how should the information resulting from the assessment be used? Is it sufficient for the provider to share with the IST and CM?**

      Yes

   b. **Is the CM required to use the information in some manner?**

      Yes. This is the intent of the statement in the policy.

7. **#1 "A Provider shall have an internal quality assurance and quality improvement system that is c. described, in whole, in a single, written policy or procedure." – It is unclear why this would need to all be included in a single policy. As long as all of the details of the required system are in place**

and can be demonstrated to policy the outcomes would not be changed by having it in one document.

The effectiveness of a well defined system when compared to a fragmented, ad-hoc system is felt to benefit everyone involved - the individual, the provider, and the state.

8. **#2 – I applaud the agencies attempts to ensure that quality is being monitored however I believe the system set up in this step will require massive additional support staff for agencies to implement in a time where the majority of agencies are cutting these departments. Many of the specific quality issues and resolutions can be re-coded in the IDT minutes upon the quarterly meeting. The progress for individual, specific quality concerns can be better tracked by the IDT quarterly as opposed to adding the layers of administrative tasks that will ultimately take away from the actual goal of quality improvement.**

   We don't believe there is any extra burden on providers than what is currently in place. This policy is just an attempt to organize these requirements that were previously all over the place.

Requirements & Training of Direct Support Professional Staff

13. **The Aversive Techniques policy (number 460 1207 003, enacted December 7, 2010) should be cited in the reference section of the Requirements & Training of Direct Support Professional Staff policy and should be included as a DDRS approved core competencies.**

    There are many more things that could be included in the DDRS core competencies, but we had to draw the line somewhere.

14. **The qualifications and training requirements for Direct Support Professionals are vital to the provision of quality services for Hoosiers with disabilities. The quality of the direct care staff is often cited by self-advocates as the biggest factor affecting opportunities for growth and general quality of life. We support the draft policy on Direct Support Professional staff as it is written and we appreciate the Division's emphasis on Person Centered Planning, communication skills and prevention of abuse and neglect.**

    We agree.

15. **#2e – Medication administration training requiring licensed nurse – While we do Core A/B training, I'm not certain all providers use nurses for this training at this time. If they do not, will current staff have to be retrained or will they be grandfathered?**

    Staff should be retrained as new orientation sessions come up. In other words, you don't have to necessarily hold special trainings just to get current staff trained, but rather, when you have a new employee or new employees getting trained include current staff in those sessions.

16. **#3 – "qualified trainers" – We will need further clarification as to what a trainer will need to be qualified.**

Bullets e. and f. have been outlined in the policy.

For bullets a. – d. there are no additional requirements beyond what is outlined in 460 IAC 6 and current policy. However, the following are DDRS' ***recommendations*** on who would be most qualified to train staff in these areas:

a. Person Centered Planning, which includes but is not limited to the following training topics:
    i. Person Centered Planning tools; - Case Manager
    ii. respect, and Individual rights; - Case Manager
    iii. choice; - Case Manager
    iv. competence; and – Case Manager
    v. community presence and participation; - Case Manager
b. Protection against Abuse, Neglect, or Exploitation, which includes but is not limited to the following training topics:
    i. the causes of Abuse, Neglect and Exploitation; - Behavior Specialist
    ii. the prevention of Abuse Neglect and Exploitation; and – Behavior Specialist
    iii. the reporting of Abuse, Neglect and Exploitation; - Behavior Specialist
c. Health and wellness, which includes but is not limited to the following training topics:
    i. universal precautions; - Nurse
    ii. personal care; - Nurse
    iii. safety during emergencies; - Provider management staff
    iv. positive behavioral supports; - behavior specialist
    v. maintaining a safe environment; - Provider management staff
    vi. nutrition and wellness; - Nurse
    vii. vehicle safety; - Provider management staff
    viii. safety during lifting and transferring; - Occupational Therapist
    ix. diet and related health issues; - Nurse
d. Communication, which includes but is not limited to the following training topics:
    i. the purpose of communication; - Provider management staff
    ii. strategies for communicating; - Provider management staff
    iii. communication with Individuals; - Provider management staff
    iv. communication with members of the Individual's Individualized Support Team (IST) and other people of significance or influence in the Individual's life; - Provider management staff
    v. conflict resolution; - Provider management staff
    vi. confidentiality of an individual's information – Provider management staff

17. **#2. e. i and, ii – Take out licensed nurse as Medicaid Waiver does not require or reimburse for nursing services.**

This is why it is important to have staff properly trained. We are not requiring a nurse on staff, we are requiring training by a nurse.

18. **Delete Direct Support Professional Staff Continuous Competency as it's redundant and adds no value.**

    Removed 1. e. from the policy. We also took out #2 – the surveyor won't hold it against the provider, but we believe it is important provider practice.

19. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

    We feel it is appropriate as written in this policy.

20. **Under the section "Initial Training for Direct Support Professional Staff," item 2. e. i - ii, there is currently no requirement for this training to be provided by a licensed nurse for services covered under the policy. This may prove problematic for some providers who do not have (nor are they required to have) a nurse on staff to provide such training. Further, it is unclear the current availability of nurses willing/able to contract with providers to offer such training.**

    We feel this type of training is very important to the health and welfare of the individuals we serve.

21. **There are no training requirements relative to outcomes and related habilitative goals, as detailed in the current rule at 460 IAC 6-14-4(b), is this correct?**

    We believe this detail is covered under #4. a. we just didn't include the same level of specificity.

22. **Direct Support Professional Staff Continuous Competency Section 2. Direct Support Professional Staff continuous competency shall be documented by the employing Provider executing and documenting: a. periodic reviews; and b. at minimum, annual re-verification. - Generally requiring all training to be annual is not something that has been stated so this is an extension of the current rules/regulations, but specifically as CPR/First Aid is listed as a "core competency" this is not an annual recertification. In the Personnel Record's DDRS policy it states the providers of this training that are available and if the American Red Cross or American Heart Association only require recertification every two years then that should be sufficient.**

    Agree. #2 has been removed from the policy.

23. **We would like further explanation of what the expectation is for "competency based training." How will this be defined? What kind of documentation will be sufficient to demonstrate this training? This language is used through several of these new policies, but there is no definition.**

    Clarified in the definition section of the policy

24. **The Medication Administration Training requirement that a Licensed Nurse complete and document the training for DSP of providers not operating group homes is a very stringent**

requirement. If a provider is a group home provider they usually have a nurse on staff, but a smaller supported living provider may not even have a contractual arrangement with a nurse.

Again, we're not saying hire a nurse on staff…just get the necessary training.

25. **Initial Training for Direct Support Professional staff #2.a.i. Person Centered Planning Tools: This needs to be defined more clearly. What exactly are the tools?**

    Non-specific items that help the team know the individual better.

26. **Under 2(e) is this requiring Core A and Core B for all DSP's? Currently, this is an ISDH requirement for group homes. We do this already and this meets the requirements listed in the draft policy and is a good thing.**

    Not specifically Core A/B, but nurse training.

27. **It mentions 18 years of age. Possibly adding to that a high school diploma or equivalent.**

    It had been mentioned to us before the policy draft was released that a high school diploma shouldn't be considered a specific qualifier to provide these services to individuals. We certainly won't stop providers from making it internal policy to only hire high school graduates.

28. **#2. b.i. indicates that the "causes" of abuse, neglect and exploitation be included in the training. That is a pretty subjective area. Perhaps the intent is to define the three areas and should read "what constitutes abuse, neglect and exploitation."**

    This has been defined in the policy and references have been made to the related policies.

29. **Requirements of the section entitled "Initial Training for Direct Support Professional staff" would restrict placing newly hired direct support professionals from providing any services until all training on core competencies has been completed. We recommend revision of the language of the draft policy to stair-step training requirements so the new hires can provide limited services in the presence of a fully trained direct support professional or trainer. Revising the language in this manner would allow new hires to experience the proven benefits of in situ training instead of having to generalize from a contrived training situation to the actual needs of the supported individual.**

    You can certainly do this as internal practice, but the DSP cannot be responsible for providing services on their own (i.e. cannot be counted in minimum staffing, and cannot be unsupervised with individuals receiving services) until they are fully trained.

30. **We noticed some new guidelines relating to medication administration and that a licensed nurse would need to train all direct support professionals on medication administration and side effect monitoring. As a provider, we see the value in this change but have a few concerns. Our first**

concern is that it might be difficult to find a nurse that could guarantee their time to come in to our weekly Orientation program since there has been such a shortage of nurses. Our second concern is that our rates continue to be cut and this has had an impact on how much we can financially spend on outside resources to assist with training programs, etc. Our thoughts were that instead of having a licensed nurse come in to the Orientation program on a weekly basis, what if there was a "train the trainer" program where a designated employee of the Provider could attend this training and become certified by a licensed nurse to teach this course to all new hires?

At this time it is our position that a nurse should train the staff directly. Often times in a "train the trainer" program the information does not get properly explained or demonstrated to the staff. This area of care is so vital to individuals' health and safety that we feel it is important to be done in this manner.

31. **The part of the outline that refers to the needed First Aid and CPR training guidelines should specify that the State wants direct staff to have CPR certification through the American Heart Association or the American Red Cross, and only these two entities, IF THIS IS STILL THE CASE.**

    I was told by BQIS during a 2010 survey that this was the case...so I think this should be specified. One of my Adult Foster Care householders had taken an on-line CPR class, and passed the class, and this was not good enough for the BQIS.

    Correct, this is still the case. This is stated in the "Personnel Records" policy. The "Personnel Records" policy has been added as a reference.

32. **Page 2, part d under communication: Should include something about confidentiality/HIPAA, if this is not provided somewhere else in the training. This is essential because there are certain things that are not appropriate to share with certain "people of significance or influence in the individual's life," not to mention that certain info (like medical) may only be able to shared with the legal representative and not merely "people of significance or influence."**

    Good suggestion. This has been added to the policy.

Use of Restrictive Interventions

1. **Positive features of this policy are the policy statement that restrictive interventions are to be temporary and used only when non restrictive behavioral support plans have been attempted and documented as ineffective. The policy also provides specific directions for incorporating restrictive interventions into behavior support plans, identifies restrictive techniques and requires mandatory staff training. The Aversive Techniques policy is also cited as a reference and this is important because staff need a complete understanding of which techniques should never be used to support individuals receiving waiver funded services. We recommend that the phrase**

"following the occurrence of unwanted behavior" be removed from the definition of chemical restraint on page 2 because any medication used to control unwanted behaviors is a chemical restraint regardless of when it is used.

We agree. This change has been made.

2. **Staff Training Required Section – suggest including the phase 'each of' to items 1, 2 and 3. So day services staff for example isn't left out – either accidently or purposefully. This wording is in the Behavioral Support Policy draft (page 2).**

   Good suggestion. This has been addressed in the policy.

3. **Reprimand – definition is severe or formal criticism – where is the line between this and verbal/emotional abuse? We certainly don't want people saying they were "reprimanding" someone when for all intents and purposes, it is an allegation of verbal/emotional abuse.**

   Agree. We have addressed this in the policy.

4. **References – include Incident Reporting and Management Policy and Human Rights Committee Policy**

   Agree. These additions have been made to the policy.

5. **Section on Incorporating Restrictive Interventions into Behavior Support Plans: we recommend this be moved to Policy- Behavior Support Plans for clarity.**
   It is currently incorporated in the BSP policy. We will keep it as is.

6. **Under # 2. Add except medications for the health and safety of the individuals**

   Agree. This has been added to the policy.

7. **Under # 5 Change monthly reports to quarterly it is unreasonable to assess BSP progress monthly, review quarterly at the IDT meetings so team can assess.**

   Agree. Change has been made to the policy.

8. **Remove all of sections "Use of Restrictive Interventions in a Behavioral Emergency" through "Medical Restraints for Health-Related Conditions".**

   Without any rationale it is difficult to assess the merit of this comment.

9. **Under section "Use of Restrictive Interventions in a Behavioral Emergency", item 1. e. and item 3., the time requirements for convening an IST meeting (within 2 business days) may be inconsistent with the requirement in the Individualized Support Team policy that require 72 hours notice for an IST meeting.**

Agree. It has been changed to match the IST policy.

10. **Incorporating Restrictive Interventions into Behavior Support Plans Section 5 discusses assessing interventions on a monthly basis and that these monthly reports should include "graphs." Currently, our behavior support service department is reporting several months worth of data in a table to show progress over time, it is unclear to us how a graph would better describe this same data. We would like more information on this requirement as there is no indication of this in any of the current regulations.**

    We would like this visual representation of progress. Tables with a jumble of numbers tend to be burdensome to look at and subsequently get ignored. With a graphical representation of trends decisions about progress can be more easily made. We don't expect this to be any extra work beyond clicking a button in Excel. Behavior data easily lends itself to graphical presentation.

11. **Interventions Determined as Restrictive Section 1. d. states: "intensive staffing for control of behavior." Hillcroft's behavior support service department disagrees with this classification as restrictive. Extra staffing with a client or at a site where significant behaviors have been reported is a proactive measure and is not restrictive in nature. Just having additional staffing at the site of services does not imply restriction of the client rights and choices often this will give the client added choices as they have more personalized assistance and attention.**

    The Department of Justice considers this to be an issue of an individual's rights when used to control behaviors.

12. **Under Medical Restraint for Procedures 2 a states Medical procedure restraints must be used only after documentation of an assessment of the efficacy of alternative positive supportive strategies to facilitate the medical procedure. – This appears to be new detailed requirements and we would like more information as to what this is referring, how it should be documented and who is responsible to complete and document the assessment. If the physician already has a standing order for a chemical restraint for specific routine procedures will we not be able to use these until an assessment is completed?**

    The Department of Justice is telling us there needs to be evidence this restraint is needed. We're not being prescriptive in what constitutes documentation or evidence, it just needs to exist in some form.

13. **Under Medical Restraints for Protection from Injury, what would be some examples of this? If the team and physician have already implemented these restraints prior to the DDRS Policy development is the team going to be required try the alternative safety measures again or document them in some way before using the restraint?**

    Again, not prescribing the specific documentation, but there should be some documentation as to why this is needed.

    Example: A helmet used in the case of intractable seizures to prevent head injury from falls.

14. **Incorporating Restrictive Interventions into Behavior Support Plans Section #3.i.vii.ii. – If the use of a PRN psychotropic is very specifically outlined in the BSP or high risk protocol, why would a**

team meeting be necessary? A meeting within two business day to include all team members is unrealistic, can the "meeting" occur electronically through e-mail?

Because the use of a PRN psychotropic medication is a big deal and the Team needs to get together and decide what they are going to do for this person to try and prevent future use.

15. **Incorporating Restrictive Interventions into Behavior Support Plans Section #7. – We were recently cited in a BQIS survey because we did not have a BSP that was very specifically only written for home and did not pertain to work/day services. Would we be expected to implement a plan that only pertains to the home environment and not work?**

    This should not have occurred and we suggest contacting BQIS if this has happened. THE BSP only needs to be implemented as written.

16. **Staff Training Required #1 and #2 – Need to define competency base training and how this is to be documented.**

    This has been added to the definitions in the policy.

17. **Use of Restrictive Interventions in a Behavioral Emergency Section #1.b. – Since by definition this is an emergency, we are assuming any appropriately trained staff is authorized to initiate an emergency intervention and recommend you changing the wording to reflect this.**

    Agree. This change has been made to the policy.

18. **Use of Restraints Section #1.a.vii. - If a restraint is approved by the individual's team and a Human Rights Committee, and restraint can only be incorporated into an individual's plan per the guidelines in your proposed Behavioral Support Plan policy, why would these need to be reportable?**

    CMS was very concerned that we were allowing the use of restraints at all and informed us that in order to continue this practice we must report all incidents involving the use of restraint regardless of the severity.

19. **Staff Training Required - The policy states that the Providers supervisory staff will train the direct support professionals. While this should be an option I feel that it should be an additional option and the Behavior Support Therapist should be the primary on training DSP's to ensure the transfer of direct knowledge.**

    While we agree with you, it has been indicated to us by Behavioral Support Therapists that this is not feasible right now. We believe this is the best, attainable approach.

20. **Pg.3. Item 1.e: Given the proposed definition of what constitutes an IST meeting, we believe that 2 days is not sufficient time to convene an emergency IST where all members (including the guardian and/or case manager) can be present. We recommend 5 days.**

    We disagree. It has been changed to 3 days in the policy to match the IST policy, but 5 days is too long.

21. **Pg.4. This implies that a direct service professional would need to get authorization prior to implementing any manual or physical restraint. This is dangerous. It appears to be taken from policies employed by State Operated Facilities where there were always supervisors and professional staff within earshot/intercom/walkie talkie – or immediately accessible. The time it would take in a community setting to get authorization from someone not immediately present to implement planned/prescribed/approved/trained manual holds to individuals with known mental illness whose behaviors may include aggression/self-injury/startle responses seriously jeopardizes the safety of individuals supported, their peers, the community and staff. This is the most troubling of all statements in the proposed new policies. We recommend that this section be amended to require authorization for the use of mechanical and/or chemical restraints only.**

    #1(a)(iii), under Use of Restraints section, has been removed. This should alleviate your concerns.

22. **Pg.5: the definition of "manual restraint" this is too broad and does not differentiate between manual restraint and physical intervention such as a brief physical hold, a physical redirect, a block which all temporarily restrict the free movement of an individual. We propose introducing a time limit – "manual restraint means using physical force to hold a person against his/her choice, which last longer than 1 minute, and which is implemented to prevent harm to self or others."**

    We disagree. We think if this type of intervention occurs there may be a need to address with a Team Meeting. If it was a onetime thing, that happens. But if it is a pattern of behavior a new plan needs to be put in place.

23. **What is the role of the Human Rights Committee?**

    In the context of this policy, a Human Rights Committee should review any use of restrictive interventions and approve or disapprove of their use.

24. **It is unclear how much of the policy applies to pre-meds before appointments / procedures. Policy states that no IR is required, but does not exclude these from steps under " 3i", including team meeting after all uses. Also need to consider if all these steps need to be taken for individuals using psychotropic medication PRN for a psychiatric diagnosis, not for behavior such as a PRN antipsychotic taken when an individual is hallucinating.**

We think the policy is very specific in regards to a medical restraint for medical procedures. 3(i) in the policy is clearly differentiated by being a component of a behavior support plan for challenging/dangerous behavior.

This policy does not address the use of medication for psychiatric diagnoses.

25. **We recommend that this draft policy be held in abeyance and redrafted on the basis of input received from a workgroup that includes DDRS-approved behavioral supports providers. As drafted currently, the policy would require behavioral support providers to complete tasks related to behavior-control medications that are medical in nature. Experience indicates that some of the tasks required of prescribing physicians (e.g., 3.i.vi) are likely to be ignored by physicians. While the intent of the policy is laudable, its application as written would be so onerous as to impede effective intervention with current resources.**

    We appreciate your concern and would welcome detailed feedback, but we feel the policy works as written. The section you reference is not new.

26. **We noticed in this policy it states that the IST needs to meet no later than two (2) business days after the use of restrictive interventions in a Behavioral Emergency. If a Behavior Support Plan is developed for a client and states that if a client does not follow the plan appropriately then they will be restricted to play video games, etc. In this instance, since the restriction is stated in the Behavior Support Plan would the IST have to meet within two (2) business days to discuss this behavior. Or does this policy just relate to items that are not stated in the Behavior Support Plan? Could you please clarify?**

    No. The example you provided is not a behavioral emergency but rather an approved plan.

27. **I have read the proposed regulations and like most of them. However, in a discussion with a couple of colleagues it appears to us that the restrictive procedure of physical restraint is requiring permission prior to use even if pre-approved by the team and HRC. In my experience, if one individual is attacking another with intent to injure or is attacking staff, there is often not time to call for permission. Can this be modified? Truly, if you have the time to call, you probably have time to safely try other interventions than restraint. I have always believed that restraint should ONLY be used if it is clear that injury to self or others will occur within 10 seconds (or is already occurring).**

    In my experience, if people are not given guidelines they can use safely, they "sneak" and do something else and simply don't tell what they've done. In so many homes, you have a single staff. It may be that staff who is being attacked and is not in a position to access a phone.

    Just to restate, you don't need permission in an emergency situation. This change has been made to the policy.

28. **Having said that, I absolutely support filing an incident report for each use of restraint and the wording on having staff trained in safe restraint. I am so glad to see face-down prone restraint prohibited--it is not safe, can be terribly frightening for the individual, and does not respect the individual's dignity. I would like to see a statement that the body is not moved out of normal body planes--that is, you can't bend the arms or legs into positions they normally aren't in. Many of the individuals I have worked with become more aggressive when things like police come-alongs are used and can end up with a dislocated arm.**

    It becomes very difficult to prescribe specific situations such as this.

29. **The current 460-6.9.3 c. 2 (Prohibiting violations of individual rights) includes the statement, "Seclusion by placing an individual alone in a room or other area from which exit is prevented." Should/could this be included under this category as well?**

    Seclusion is an Aversive Technique and is included in the "Prohibited Interventions", #3.

Whistleblowers

1. **We recommend that number 3 be changed from "enforce a policy and procedure in compliance with IC 22-5-3-3 that includes protections for whistleblowers who report violations of" to "enforce a policy and procedure in compliance with IC 22-5-3-3 that includes protections for whistleblowers who report to the employer or to BDDS violations of". We also recommend that a number 4 be added which states "Provide a copy of the policy to BDDS." In the references section IC 22-5-3-3 should be added as it is referenced in number 3.**

    Agree. This section has been moved to the "Provider Code of Ethics" policy. These suggestions should now be addressed.

2. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact"**

    Absolutely not, of course whistleblower protections apply to all individuals associated with the company.

3. **This seems to be a restatement of items 9 and 10 under the Provider Code of Ethics. Why can't these two policies be combined for brevity?**

    Agree. The "Whistleblower" policy has been incorporated in the "Provider Code of Ethics" policy.

4. **No definition of whistleblower.**

    IC 22-15-3-3 – cite is listed in the references section.

General Comments

1. **If there is going to be a policy regarding Staff Training, should each of these drafts (as appropriate) reflect that (under the References section)?**

   Yes. Policies affected have been updated.

2. **Is a Medication Administration Policy being developed?**

   It is currently included in the "Health Care Coordination" policy. This policy will made available for public comment with the next group of policies.

3. **We object to the DDRS policies not being included in the IAC 460 regulations as it allows requirements to be changed without an opportunity for public review**

   We feel these policies need an element of flexibility not afforded by the official promulgation process. With that being said, we are willing to state in 460 IAC 6 that policies related to this rule must be subject to public review.

4. **It is not clear which policies the Group Homes must adhere to – please be more specific.**

   Incident Reporting and Management policy affects Waiver, Stateline, and Group Home providers. But in general, these policies are for Supported Living providers. Group Home policies guided by 431 IAC X will be reviewed in the future.

5. **Throughout the policies that refer to owner, director, contractor, subcontractor, etc" we recommend it state: employees and persons who have "<u>unsupervised</u> client contact" Delete owner, director, officer, contractor, subcontractor, and agent. We do not agree that those with either no client contact, ex. contracted/subcontracted persons who paint or fix heaters or those who have contact with clients in a supervised setting, ex. DJ's and Dance collective, should be included in the regulations. Too costly and adds no value**

   We have addressed this concern in each policy in which you stated this concern. Some instances made sense, many others absolutely did not.

6. **An economic impact study should be conducted to identify how the policy changes will affect all providers and stakeholders.**
   When we promulgate 460 IAC 6 an economic impact statement will be submitted prior to issuing our Notice of Intent.

7. **Overall we should just be required to follow the current regulations – if adherence to current regulations was verified on a regular basis there would not be an issue.**

   Many current regulations are inadequate or out-dated. Just like any organization we must adapt to the times. Imagine if this argument was used and upheld when the decision to move towards de-institutionalization of this population was made. Change can be a positive thing.

8. **General Comment Regarding Personnel Type Policies: How and to what extent do these types of policies apply to volunteer Boards of Directors who have no direct support responsibility for individuals receiving services?**

   We've addressed where applicable.

9. **Some of the policy language within the Draft DDRS Policy documents appears to be more restrictive and have more requirements than the current rules and regulations including the 460 IAC 6. Is it the intent that the provider will now be surveyed and held accountable to the policies instead of to the regulations including 460 IAC 6?**

   Yes. These changes will be reflected in an updated version of 460 IAC 6.

10. **The training provided by BQIS and Liberty Healthcare of Indiana titled "Incident Management" and dated March of 2009, and the training document which is still available on the BQIS website were very helpful resources. However – several state board of health surveyors and BDDS field service coordinators seemed to have several different versions and variations of what requires a state report and are holding providers to interpretations dated in 2007 and 2008. Our request is that when the policies are finalized, BQIS offer identical training and materials to providers, state board of health surveyors, and BDDS field service staff.**

    There will be training on February 15th. Details were sent out to all providers.

11. **I would like to see a policy where in an emergency the RHS provider may train on the BSP, but a follow-up with the behavior clinician be arranged as quickly as possible. I will tell you that when a RHS provider says they need a staff trained on the BSP, I arrange for that to happen quickly so they are covered. I have had RHS providers call and say the need someone trained by the next day and I work with them to get it done. I am sure there are times when this may be a burden, but it seems that this is the best way to support the individuals with which we work.**

    The "Use of Restrictive Interventions" policy states the RHS providers will have a policy to address emergency situations.

12. **What is the anticipated relationship between these proposed policies and the current 460 Rule 6? Many of these policies and procedures are similar in nature to those in Rule 6. Once these are implemented, does Rule 6 go away?**

    Rule 6 does not go away, but rather will be promulgated to reflect these changes.

13. **Would it be possible for y'all to provide us with a protocol for when a team should request guardianship be considered for a client? Without guidelines, it is completely left up to the team. Sometimes an individual is so impaired in communication skills that the "team doesn't have any problems with him/her" and so it is, really, rather convenient not to have a guardian--but the individual is left without anyone to be his/her voice. Sometimes an individual is left alone "own self" until he/she is making detrimental decisions for health or safety, and then the process takes a long time and one wishes it had been done so that a guardian and the individual have some**

knowledge of each other and rapport before "someone else" is making decisions. Sometimes it doesn't matter until an individual is sick or being influenced by someone or something dangerous...

If we had a protocol or guidelines, the team could check those annually, see if there is any need, and then put it away. There would be no danger that a situation would develop where a residential company disagreed with the individual and then wanted a guardian; or an individual who might have benefitted from someone helping oversee from just the individual's perspective didn't have that.

Last summer, we had a client who proposed getting married to someone who said up front he was going to pull her out of services and take her off all her medications as soon as they were married. When the team investigated (after an anonymous allegation), it turned out he was a sexual perpetrator and had a history of relationships with women "on checks" to take their money. We finally went to court to see about guardianship for her, and the court was appalled that she had been "permitted" to have a sexual relationship. When we explained it was her right, the court indicated we were being silly.

And yet, I can't find any guidelines other than "what the team thinks".

A policy on guardianship will be available in the future.